EXHIBIT A

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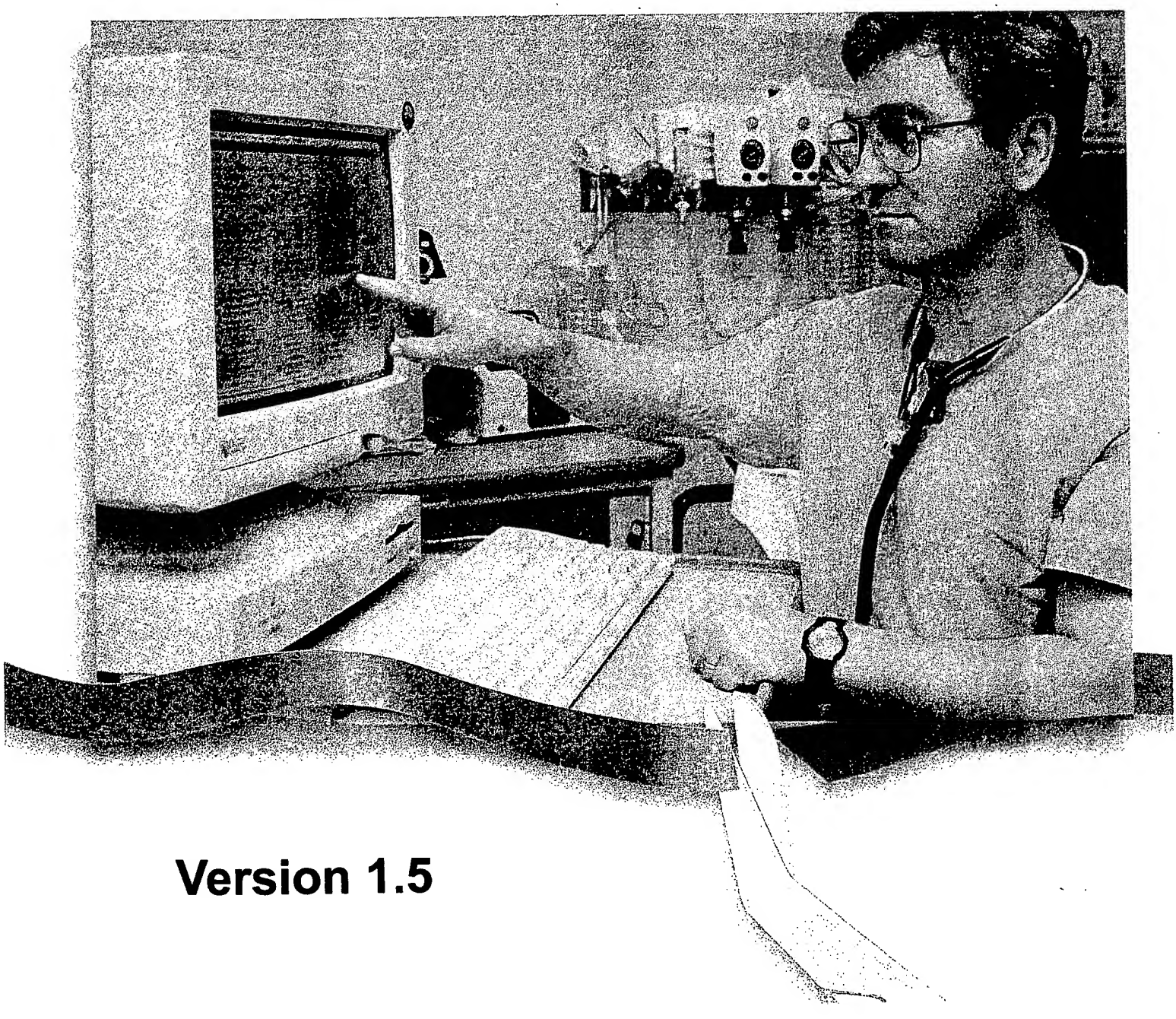
TeleMed

User's Guide



Version 1.5

User's Guide

TeleMed™

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RLIS, Incorporated

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Contents

Chapter 1: Introducing TeleMed

TeleMed is designed to complete repetitive, time-consuming documentation tasks in a fraction of the time it usually takes, so you can concentrate on using your medical knowledge to deliver quality patient care. TeleMed captures the patient data once, then lets you build on the patient's record as new information becomes available thereby allowing Emergency Department staff to concentrate on the patient rather than the patient record. With its speed and ease of use, TeleMed demonstrates it is truly a system that understands the urgency of emergency department operations.

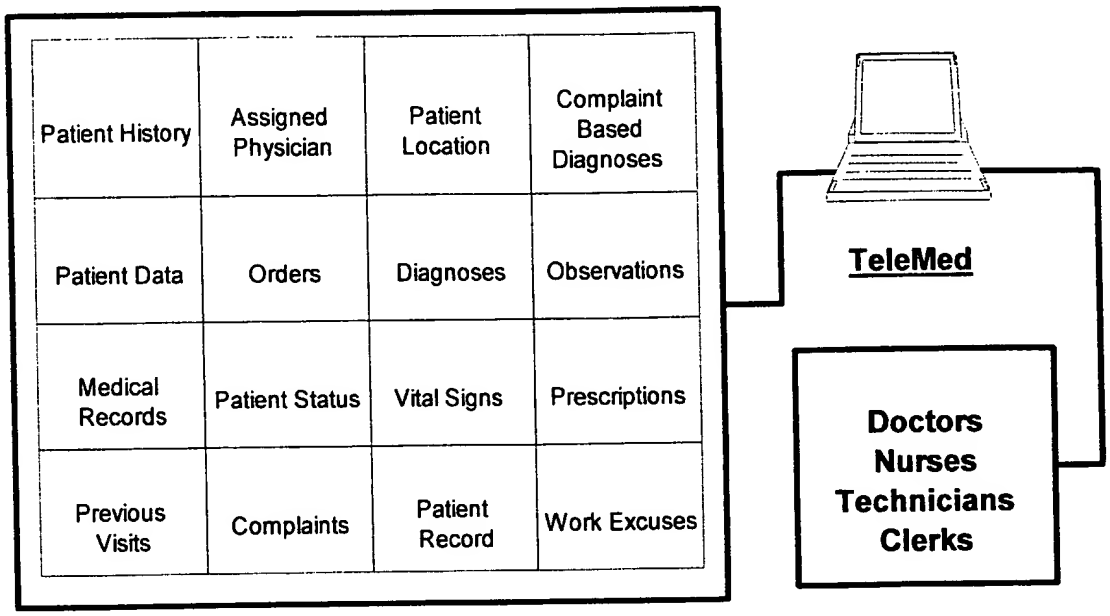

Figure Chapter 1: -1: Type of Information Managed by TeleMed

(Image:tm-3.af3)

From any station, members of your emergency department staff can review up-to-the-minute status of patients or update their medical records.

TeleMed's technology helps your medical staff document their observations and diagnoses as quickly as they make them. It displays comprehensive lists of potential diagnoses based on the complaints they select and takes them logically through the steps when a new patient appears at the door. From complaint to consultation, from diagnosis to referral, your emergency department physicians will be spoiled by the immediacy of response and the ease of moving between screens to capture information on each patient.

With a terminal at every bedside, nurses' station, and doctors' workroom, TeleMed allows everyone in your emergency department operation access to the vital information they need to do their jobs. It centralizes the patient medical record, retrieves data and allows you to review a patient's previous visits. It can identify patient location and status at a glance, so you can tell which patients have not been assigned a physician and where your empty beds are.

With TeleMed, you can dramatically reduce your dictation and transcription costs. Most of the medical record is documented directly by TeleMed without dictation. The system takes entries and translates them into a plain English sentence format that is comfortably familiar. When the physician is working on a patient, that information is entered directly into the medical record. The physician then focuses attention on the patient's condition, potential diagnoses, tests required, and medications to be given. This not only speeds the documentation process but avoids clerical errors associated with dictation. Transcription errors are easily corrected at any terminal.

Documentation has always been a burden but with TeleMed, we make it a pleasure. Each staff member will have a sense of relief at the reduction in paperwork which will in turn boost morale and reduce turnover. The computer software takes care of most of the redundant, administrative headaches and allows your medical staff to focus on patient care and treatment.

Documentation has become a necessary evil for most medical facilities. With TeleMed, every case is thoroughly documented. Physicians and nurses contribute to the overall picture of each patient, and discrepancies can be resolved immediately rather than after the fact. Calls to primary or consulting physicians are logged so you track when events occurred. Requests to various departments for tests are logged and printed. When those results are received, the status changes on the screen so physicians know when new information is available.

With over 200 screens to assist you and easy, logical paths between them, TeleMed provides powerful support to all your medical staff. By tailoring our system to emergency department operations, the administrative functions of creating medical records and managing patients becomes enjoyable.

With TeleMed, your emergency department can be more profitable, more productive, and more professional. Designed by an emergency department physician, the TeleMed system helps your emergency department physicians practice medicine, rather than focusing 40% of their time and energy on documentation.

With the TeleMed system in place, you can work more effectively and quickly to handle patients in the emergency department. That translates into higher volume for your hospital, improved patient care and ultimately greater efficiency for your physicians. When patients arrive and are faced with significant delays, they will seek care elsewhere. TeleMed helps eliminate those delays. Patients are evaluated, treated, and discharged from the emergency department in a quick, thorough and consistently reliable manner.

TeleMed Tasks And The Typical Roles That Perform Them

The following chart lists some of the typical roles and associated tasks they can perform with TeleMed.

	Doctor	Nurse	Tech	Clerk	Comment:
Enter New Patient	•	•			
View Clinical Summaries	•	•			
Edit Doctor Drug Preferences	•				
Create Prescriptions	•				
Order Medications	•	•			
Order Therapeutics	•	•			
Generate Reports	•	•		•	
Quit Program	*				Optional
Edit Users	*				Optional
System Manager	*	*			Optional
Delete Insurance Plans	*				Optional
Edit Prephrased Text	*				Optional
Sign Physician Med. Record	*				Optional
Sign Nurse Medical Record		*			Optional

Table Chapter 1: -1: Typical TeleMed Tasks & Roles Chart

NOTE: The tasks that an individual is authorized to perform in TeleMed are driven by your medical operation's policies and procedures. This chart is intended to familiarize those new to TeleMed and is not intending to influence your medical operation's policies or procedures.

Chapter 2: Getting Acquainted with TeleMed

Active Patient List (Main Tracking Screen)

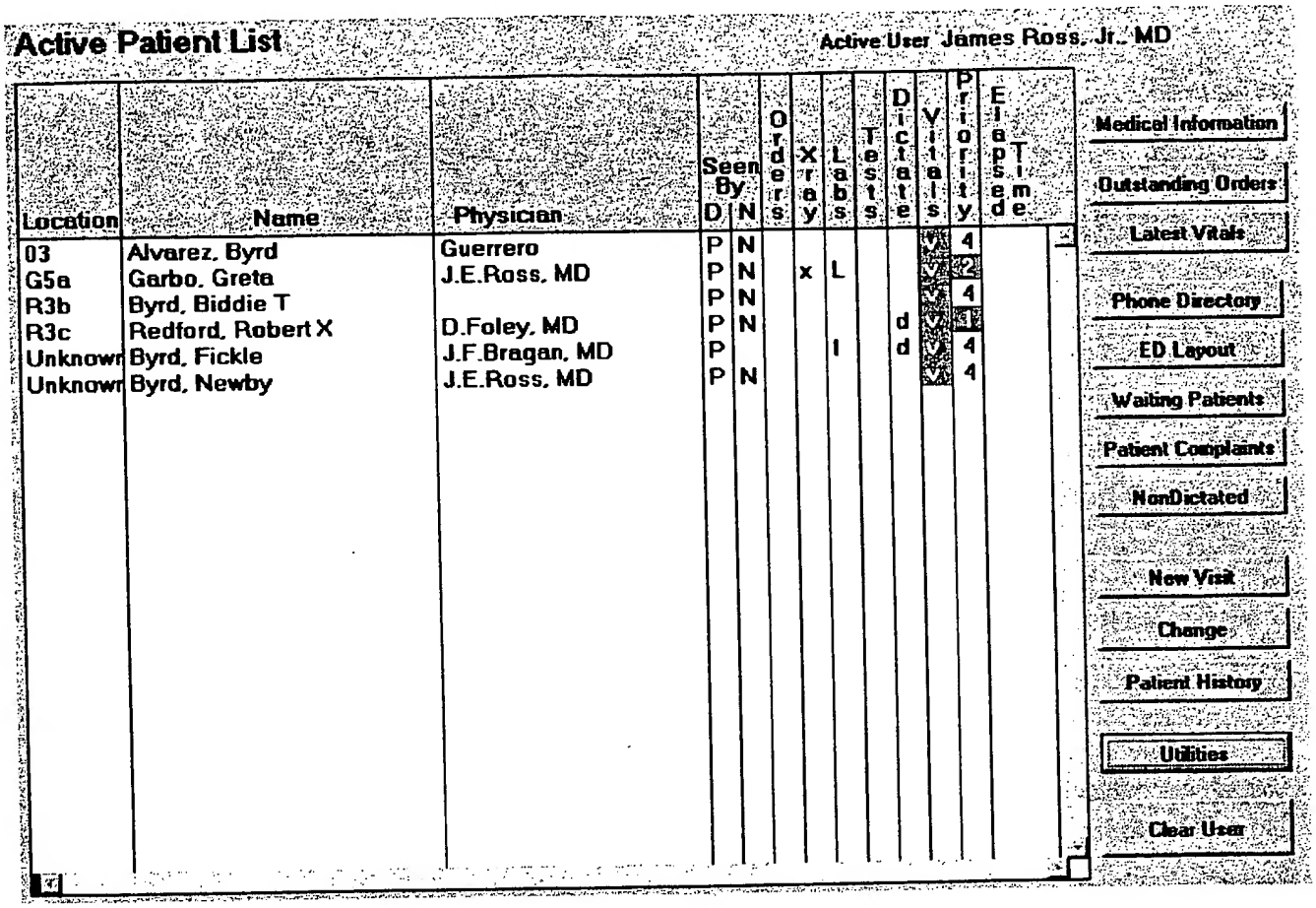

Figure Chapter 2: -1: Active Patient List (main tracking screen)

(Image: tm-2.bmp)

When you "log in" to TeleMed (via your "smart card"), you will open the "Active Patient List" window. Treat this as your Emergency Department's "main tracking screen".

Medical Information (Main Patient Information Screen)

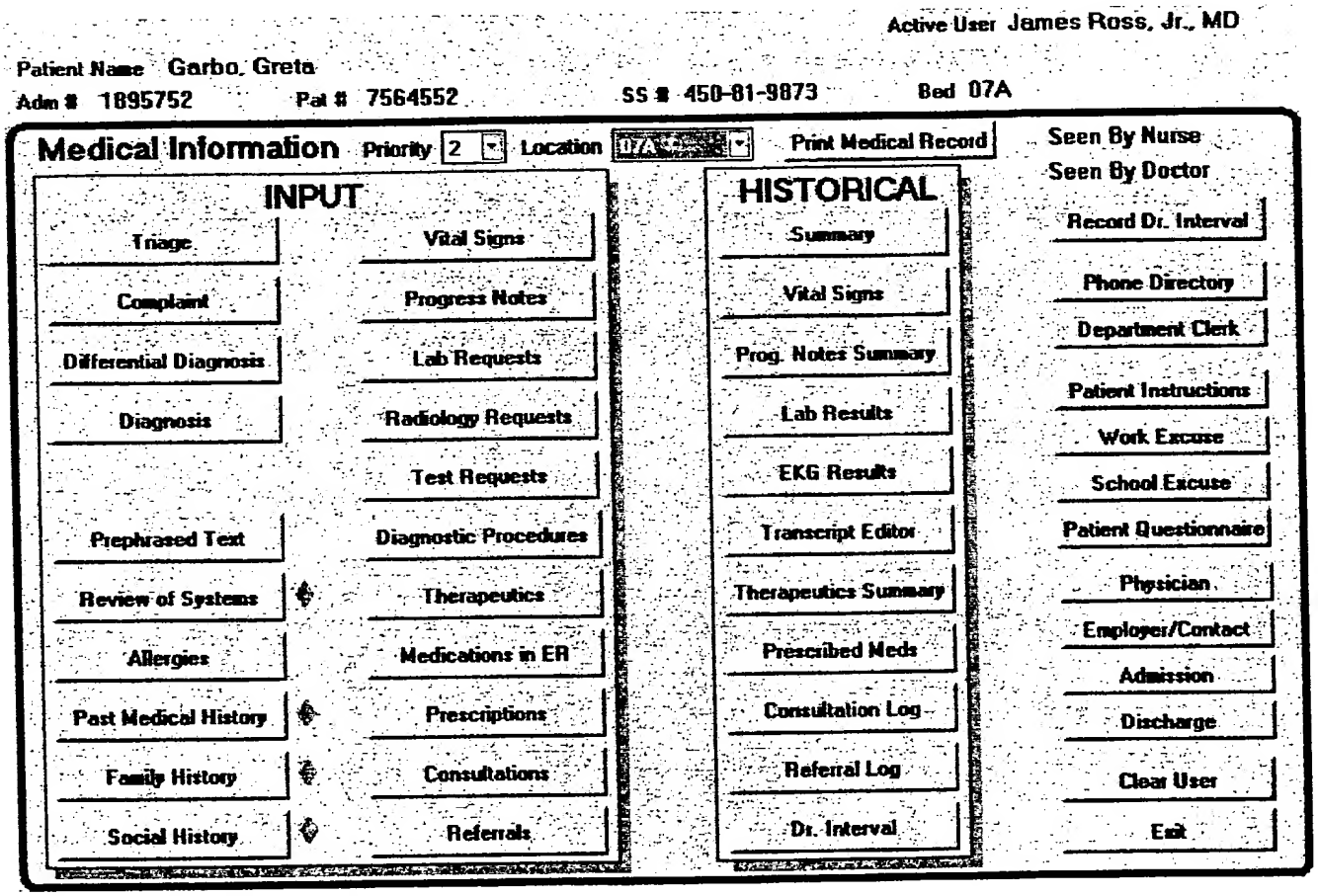

Figure Chapter 2: -2: Medical Information (main patient information screen)

(Image: medical-info.bmp)

With a single touch of the screen, you can move painlessly through other screens to capture history, enter vital signs or give orders to others. Treat this as your "main patient information screen".

Complaints/Diagnoses

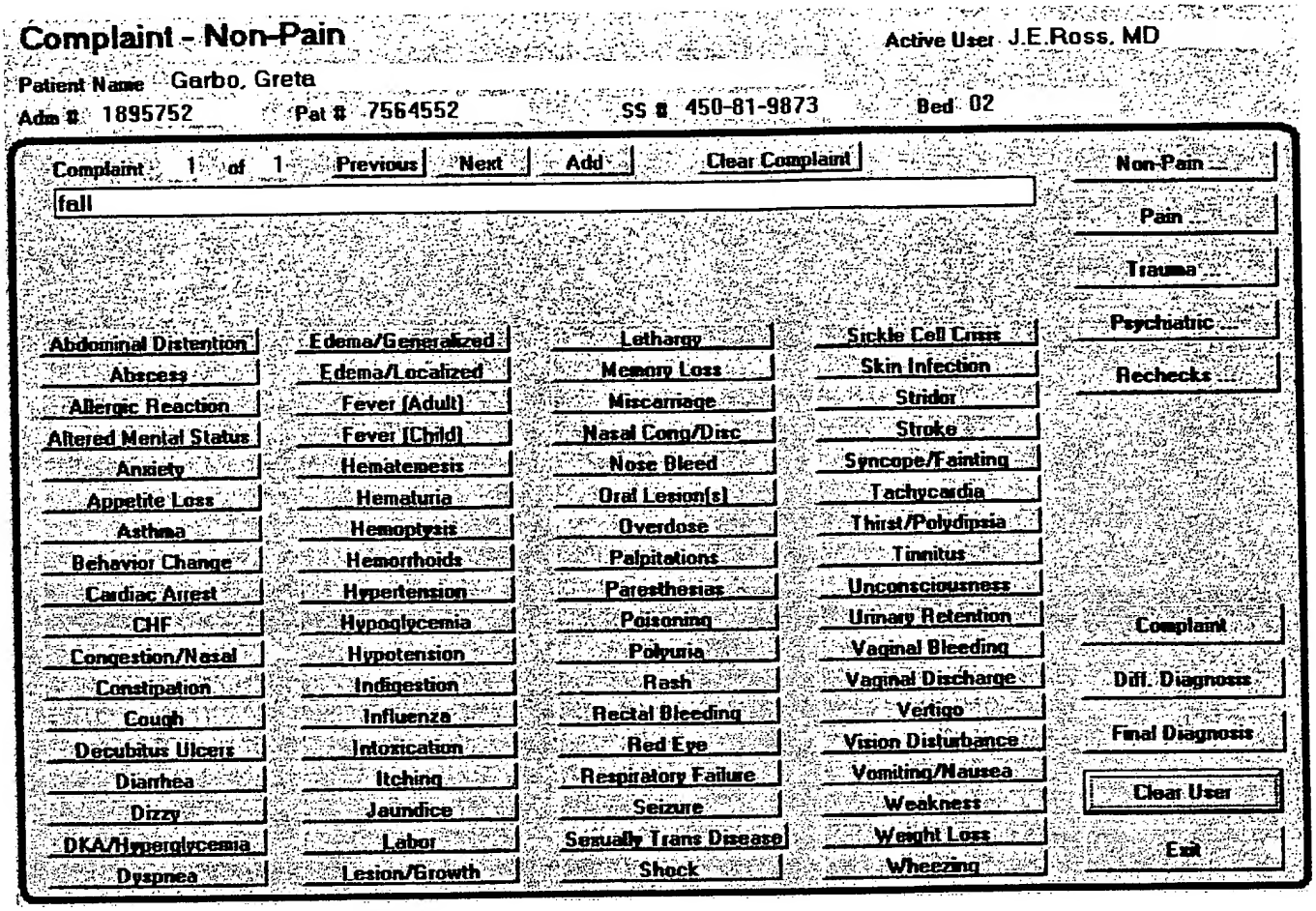

Figure Chapter 2: -3: Complaint Screen (Non-Pain)

(Image: complaint-non-pain.bmp)

TeleMed displays listings for trauma and non-trauma complaints. You select as many complaints as apply to the patient. For non-trauma complaints, TeleMed creates a complete list of potential diagnoses, as well as a shorter list of more probable causes. The physician may add or subtract from these differential diagnoses to reflect the causes which were considered. In trauma cases, the physician selects a direct diagnosis, such as burn. Once the final diagnosis is selected, the appropriate information is automatically added to the patient's exit instructions.

Diagnosis (Graphical)

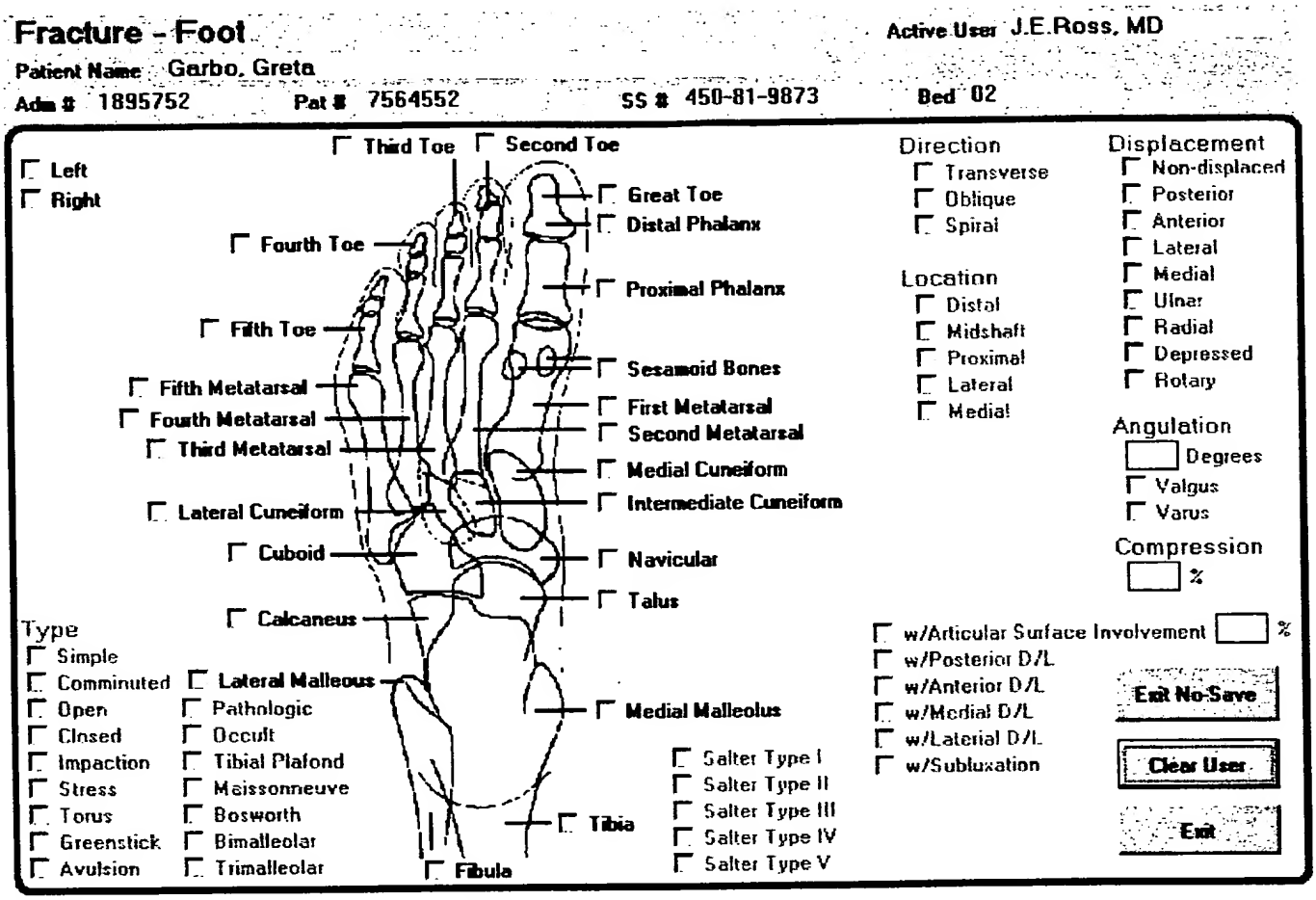

Figure Chapter 2: -4: Graphical Diagnosis Screen (typical)

(Image: graphics-foot.bmp)

Often, helpful colorful graphics are provided. In the case above, fracture diagnoses with their modifiers can be quickly entered.

Review Of Systems

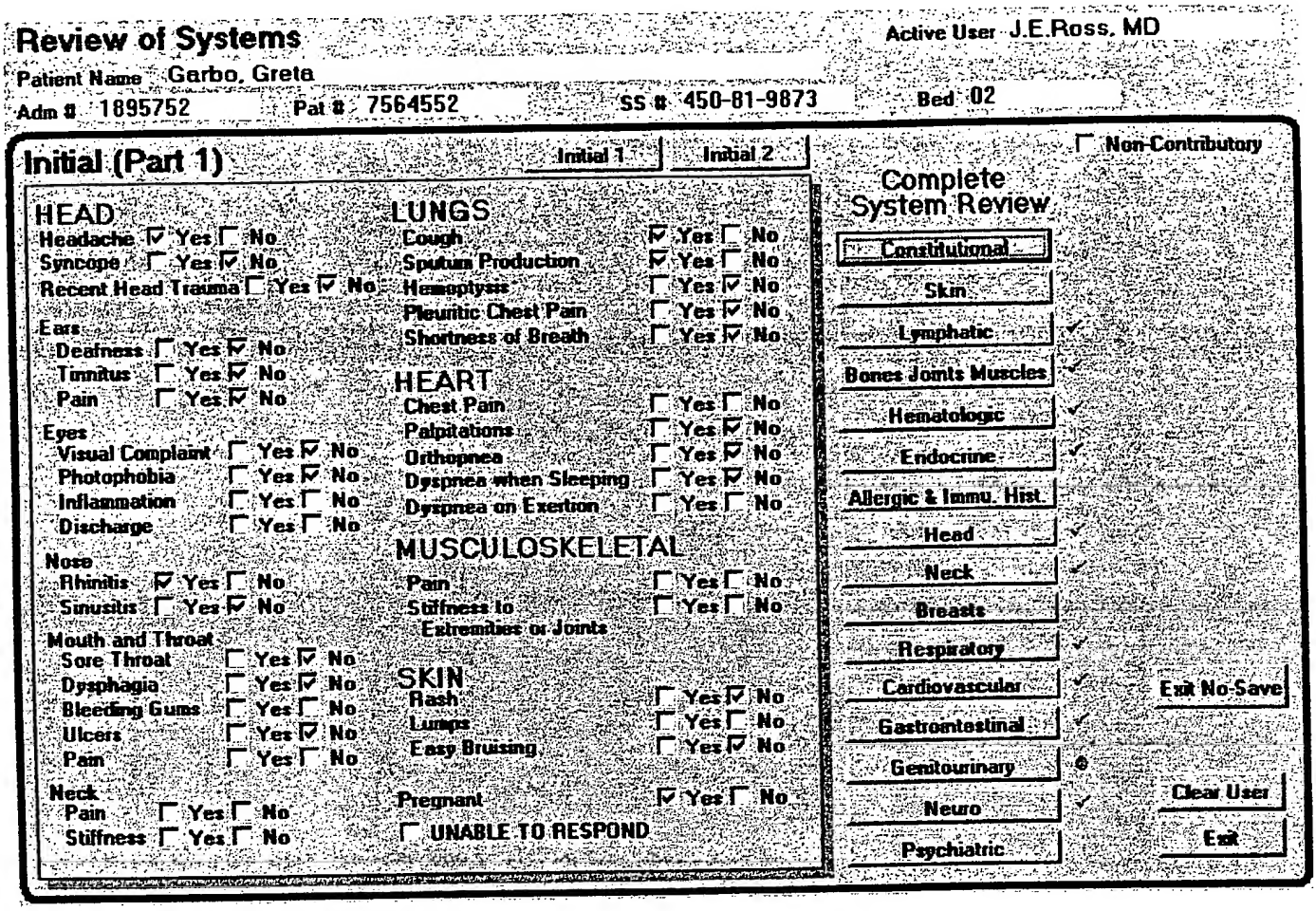

Figure Chapter 2: -5: Review of Systems Screen (Initial - Part 1)

(Image: review of systems.bmp)

TeleMed provides comprehensive groupings of all systems and allows the physician to move freely back and forth without the tedium of exiting through a number of screens. You only enter what is needed without being forced to enter unnecessary information. TeleMed then generates the appropriate level of documentation to maximize billing.

Past Medical History

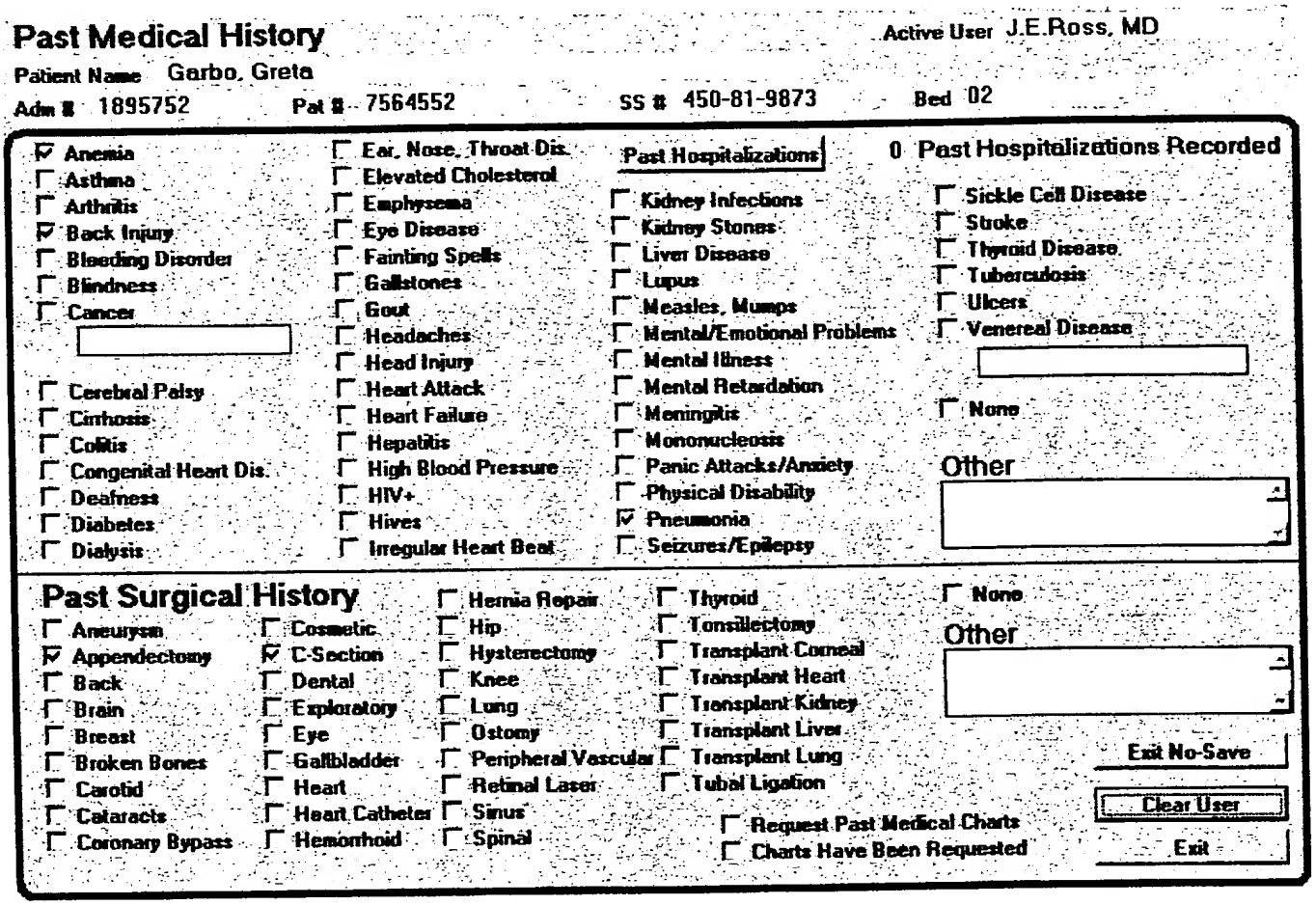

Figure Chapter 2: -6: Past Medical History

(Image: past-med-history.bmp)

You can now look up a patient's past medical history without ever touching a stack of paper. Prior visits can be reviewed easily and quickly by identifying the patient by name, Social Security number, or medical record number.

Allergies

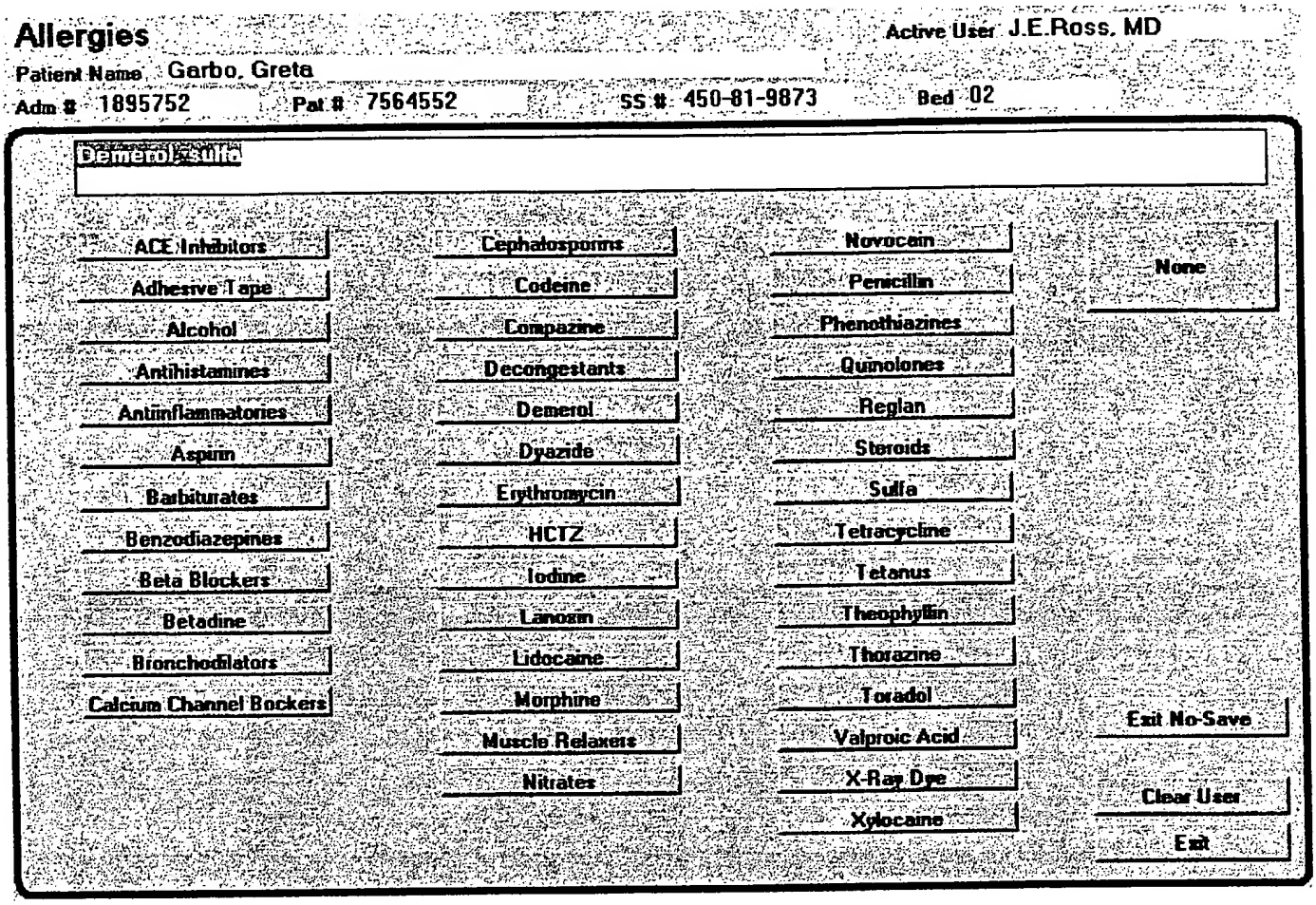

Figure Chapter 2: -7: Allergies

(Image: allergies.bmp)

A patient's known allergies may be entered for this visit and/or retrieved from previous visits to help avoid medication incidents in therapeutics, prescriptions or where nurses "take off orders." When a patient enters the emergency department alone or unconscious, your medical staff has the immediate advantage of getting this vital information from previous visits. Drug allergies are listed in red on screens where medications are ordered or prescribed.

Family And Social Histories

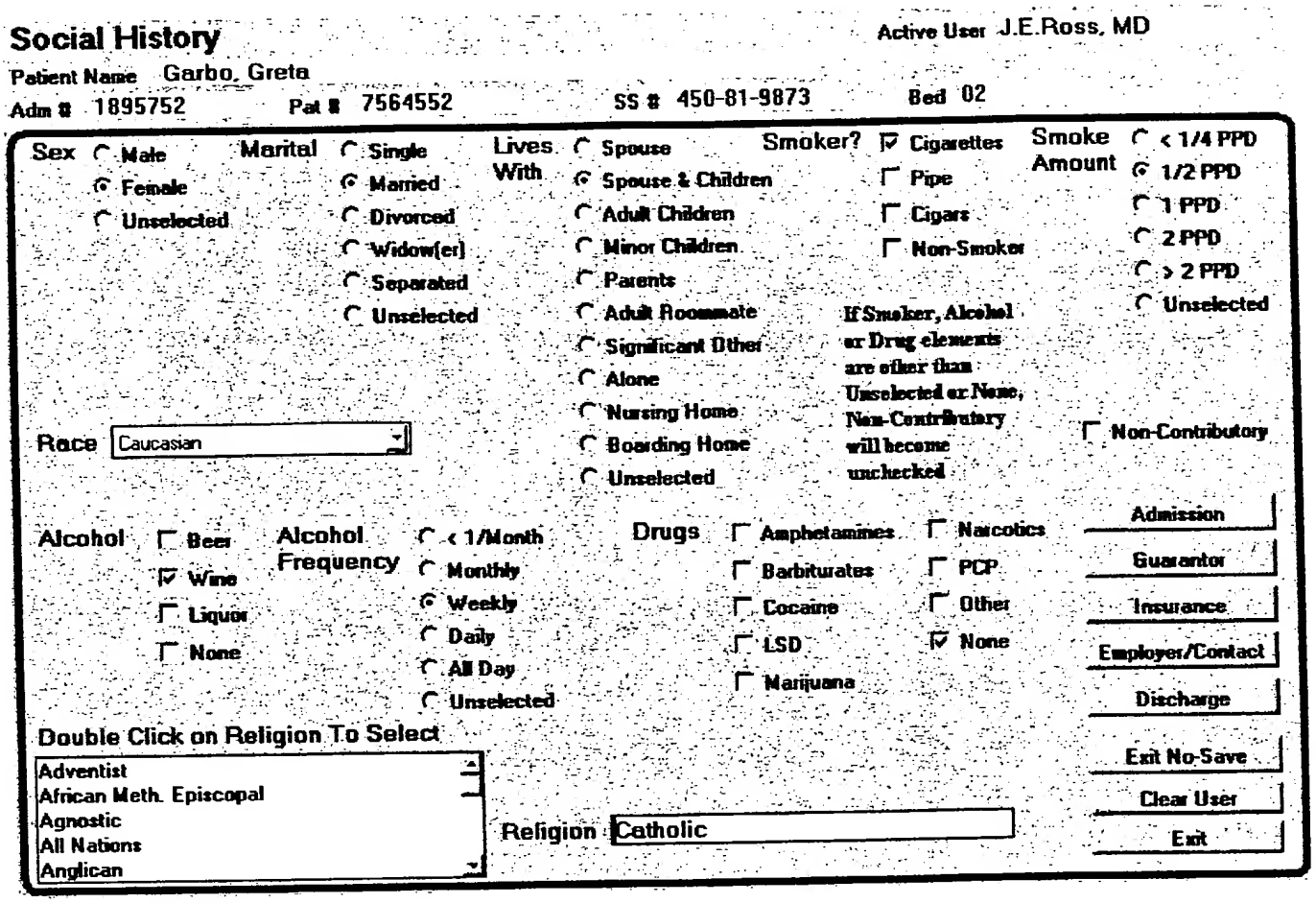

Figure Chapter 2: -8: Social History

(Image: social-history.bmp)

Vital clues to a patient's condition may be available by accessing the family or social history. Regardless of who collects the information, it is available to the entire staff.

Lab Requests And Results

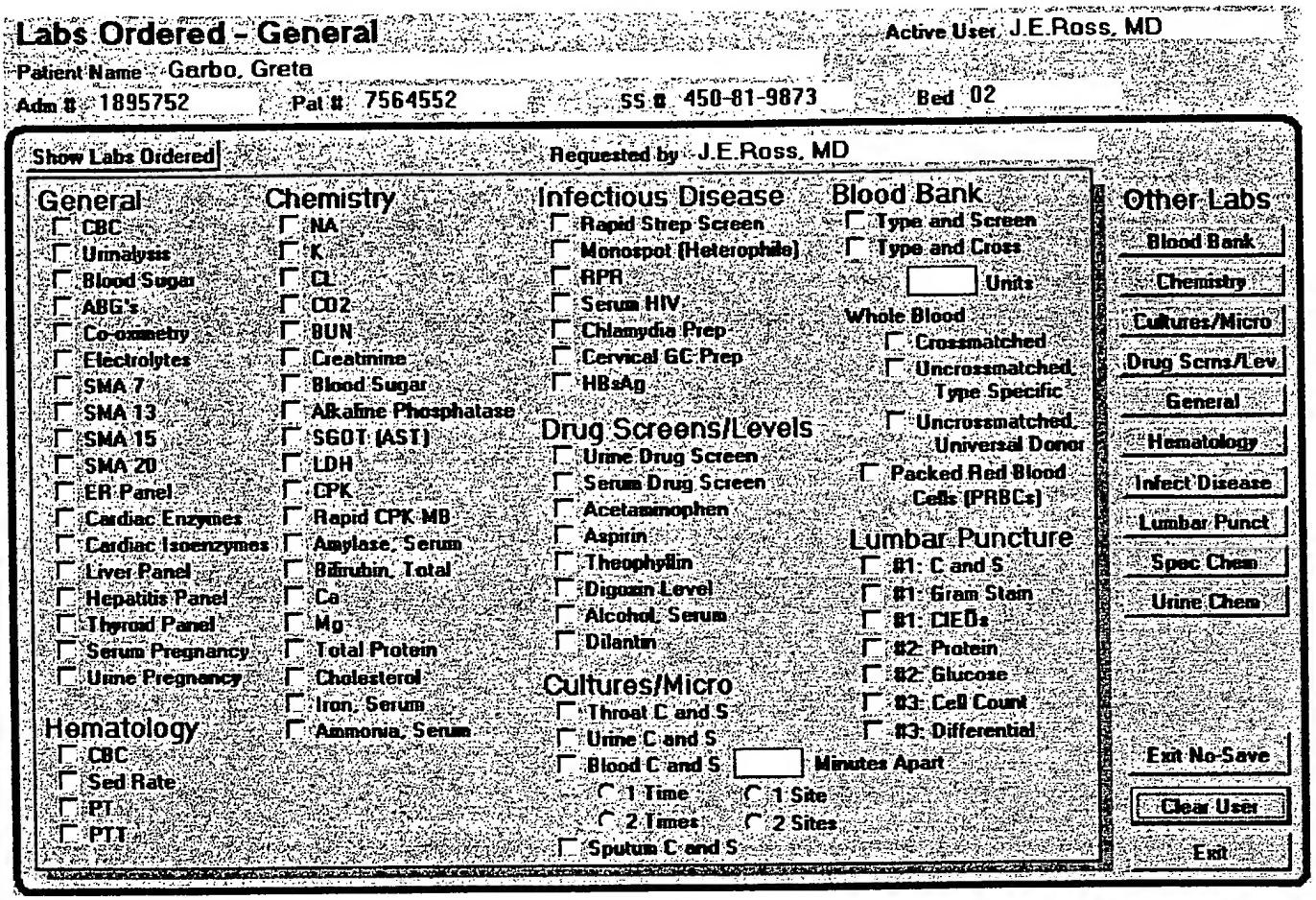

Figure Chapter 2: -9: Labs Ordered - General

(Image: labs-ordered.bmp)

When tests are required from the lab, radiology or another department in the hospital, orders may be entered and printed for these tests. Once results are available, the patient's record is updated and the screen indicates the completion. At a glance, you can tell what is still outstanding.

Therapeutics/Procedures

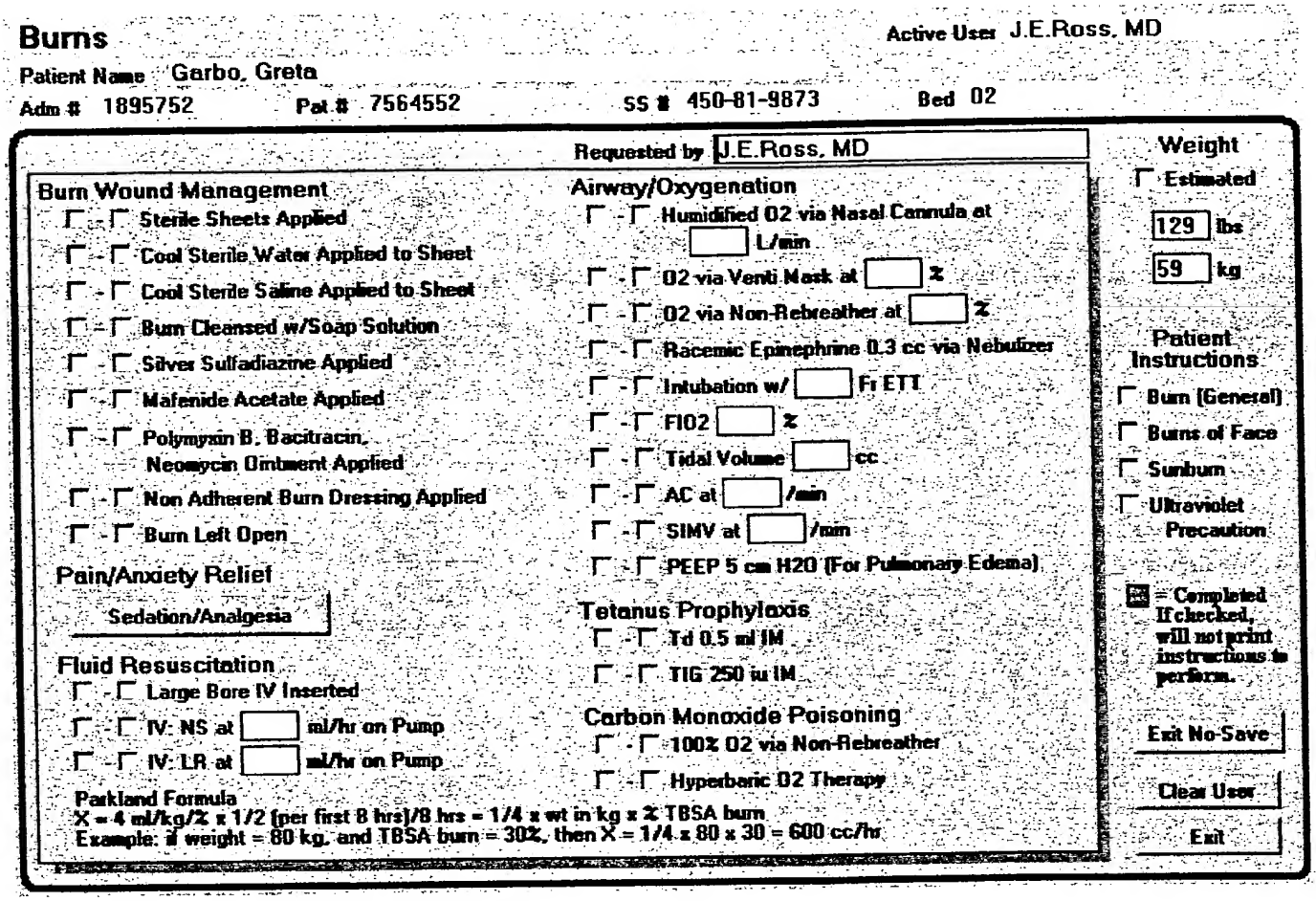

Figure Chapter 2: -10: Therapeutics - Burns

(Image: burns.bmp)

TeleMed permits rapid, thorough documentation of all procedures and therapeutics performed. It allows physicians to instantly generate printed nursing orders.

Prescriptions

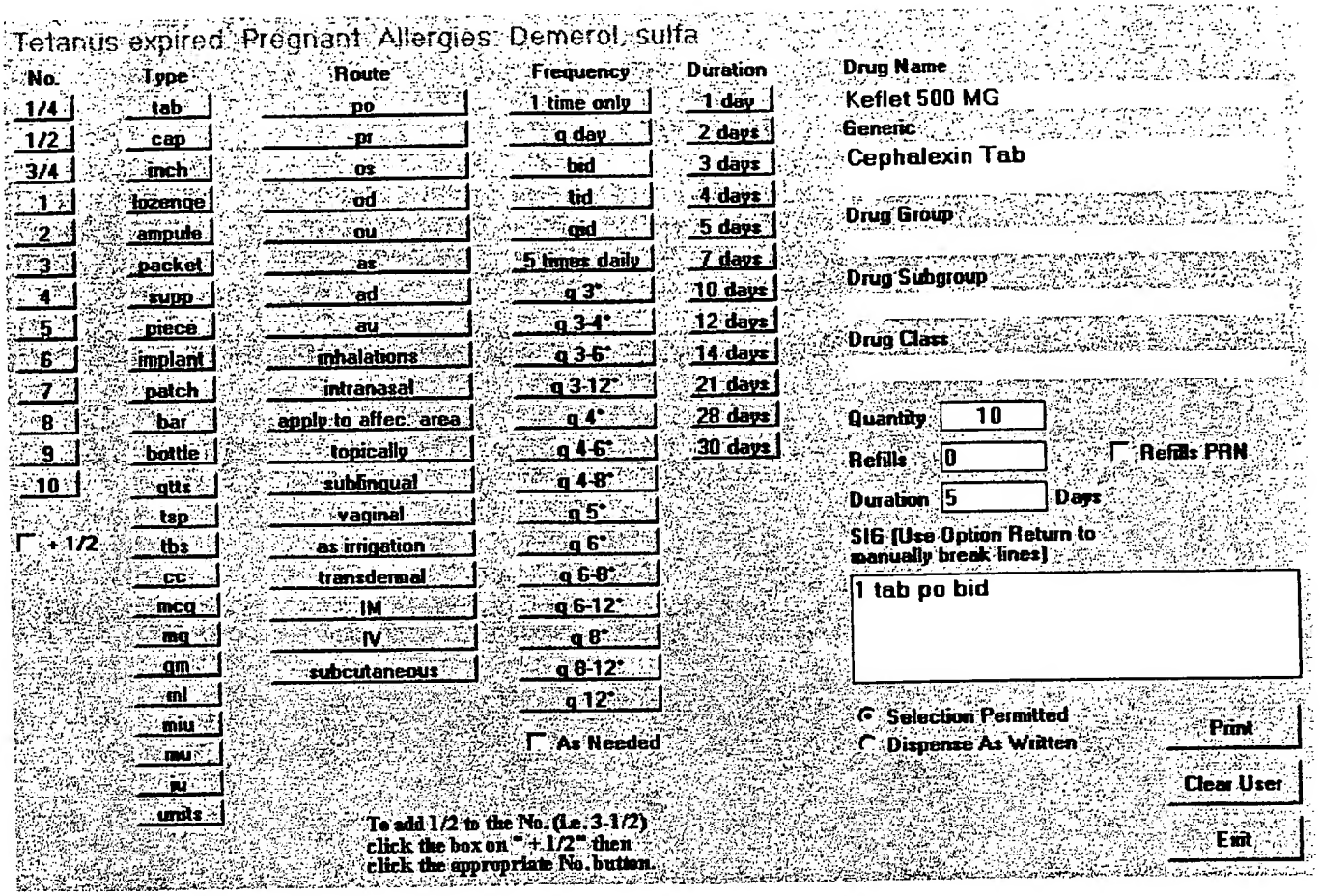

Figure Chapter 2: -11: Prescription Screen - Keflet

(Image: prescrip-keflet.bmp)

Writing prescriptions has never been easier or faster. You can select from your personal custom list of drugs, prescribing just the way you prefer, and with only three quick touches of the screen, your prescription is printed. Or you may expand your choices by entering the first few letters of the drug name, and TeleMed displays a comprehensive alphabetical listing. You can also view drugs by function classification to select the appropriate one. TeleMed lets you select or change the dosage, route, frequency and duration to fit the specific patient. Individual patient allergies are always displayed on the screen to avoid medication incidents.

Often patients fill their prescriptions away from the emergency department. Although instructions and warnings may be provided by the dispensing pharmacy, if someone other than the patient is getting the prescription filled, they may not have the same concerns or questions that the patient might. The prescription portion of the TeleMed system places the printed instructions in the patient's hands while they are still in the emergency department with staff members who know their condition and can answer their questions.

Referrals & Consultations

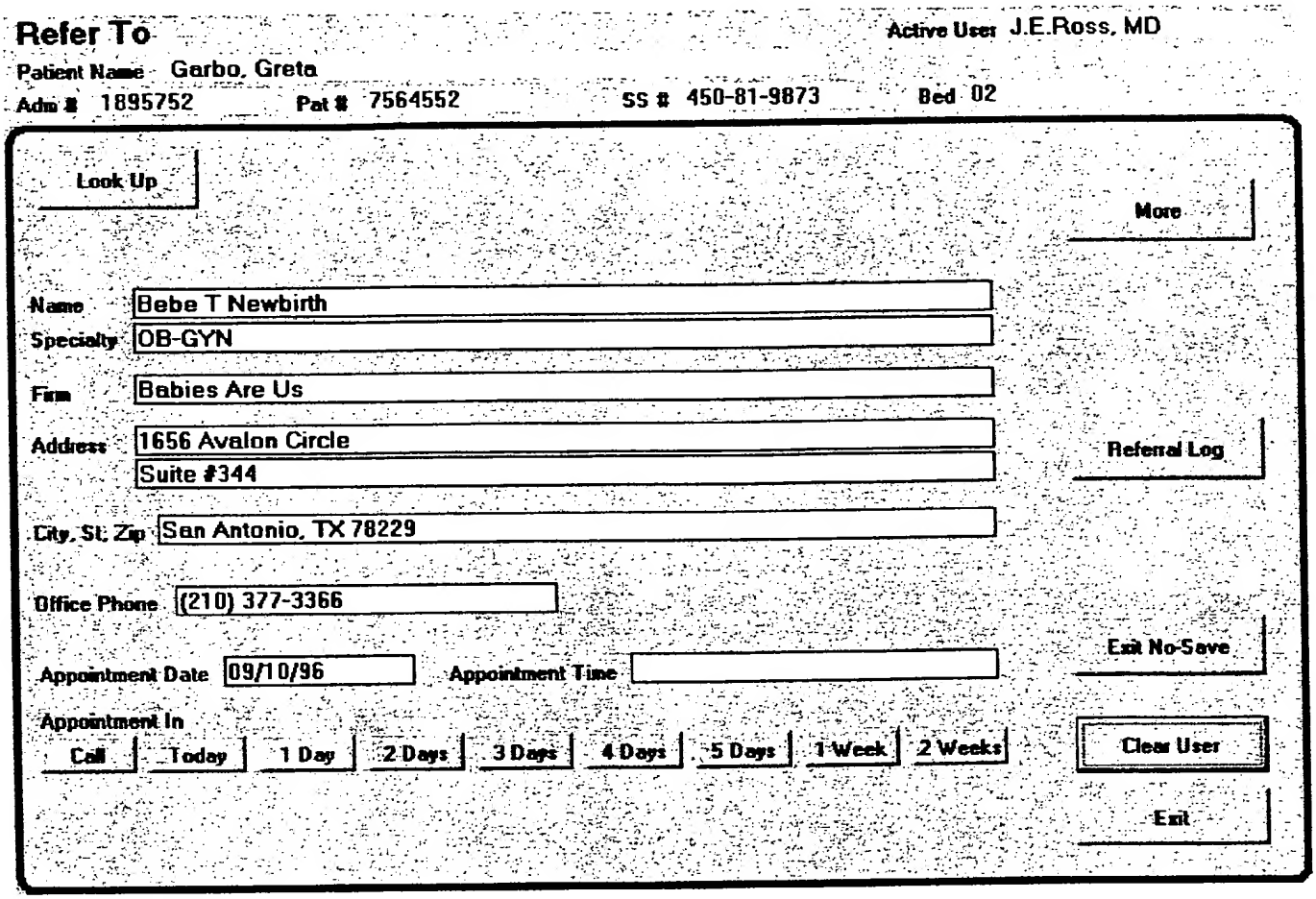

Figure Chapter 2: -12: Referrals & Consultations

(Image: refer-to.bmp)

With TeleMed you can log all calls and conversations with primary or consulting physicians, so they become a permanent part of the patient's record. A full directory of physicians is available instantly. The physician directory includes referral patterns so you can go directly to the right doctor. When the patient is referred, the exit instructions show the doctor's name, specialty, office address, phone and even appointment date and time if one has been made.

The Medical Record

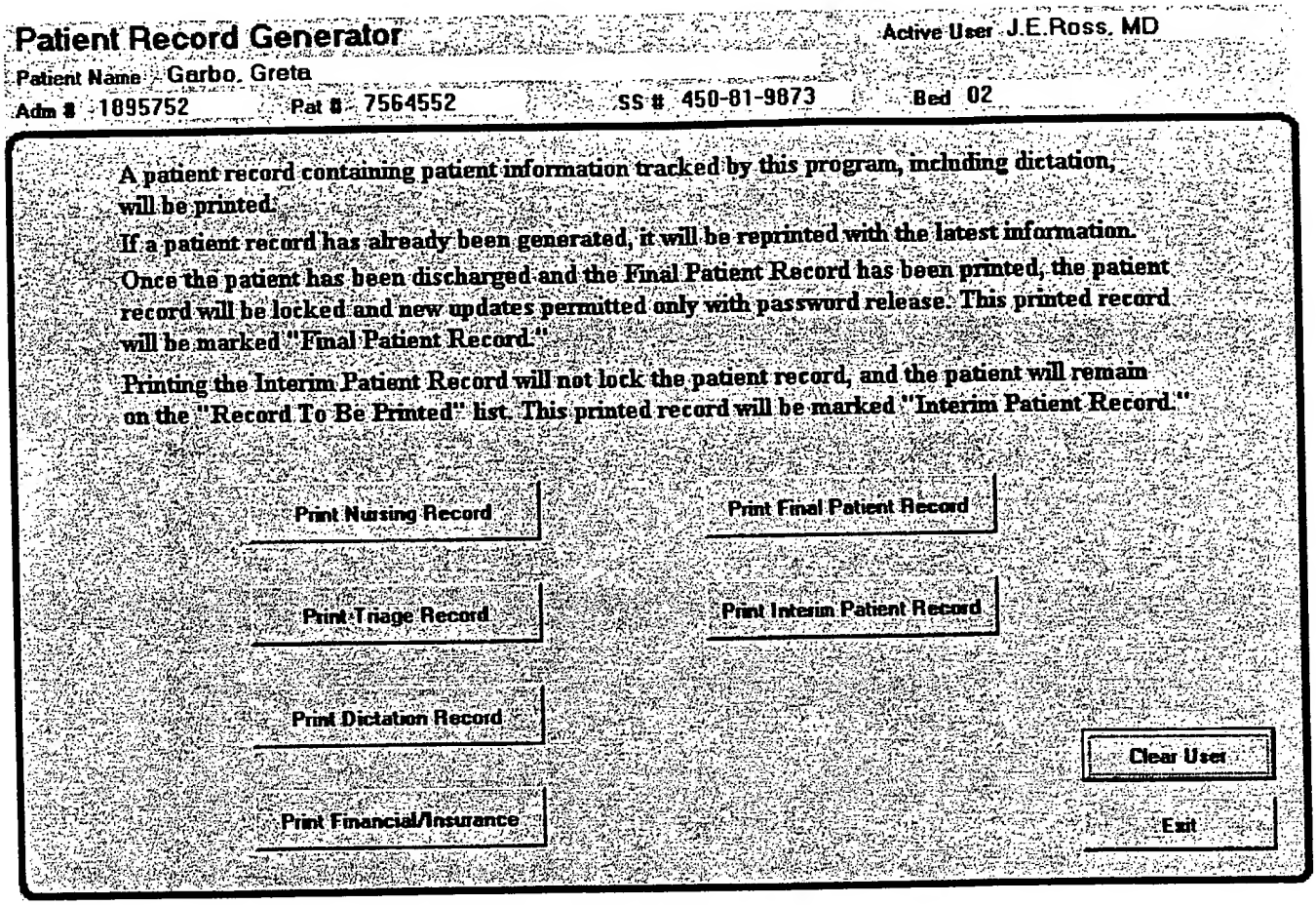

Figure Chapter 2: -13: Patient Record Generator

(Image: patient-record-generator.bmp)

When you have completed your care, the medical record is printed out in a clear, readable, plain English sentence format as if you had dictated it.

The Medical Record (continued)

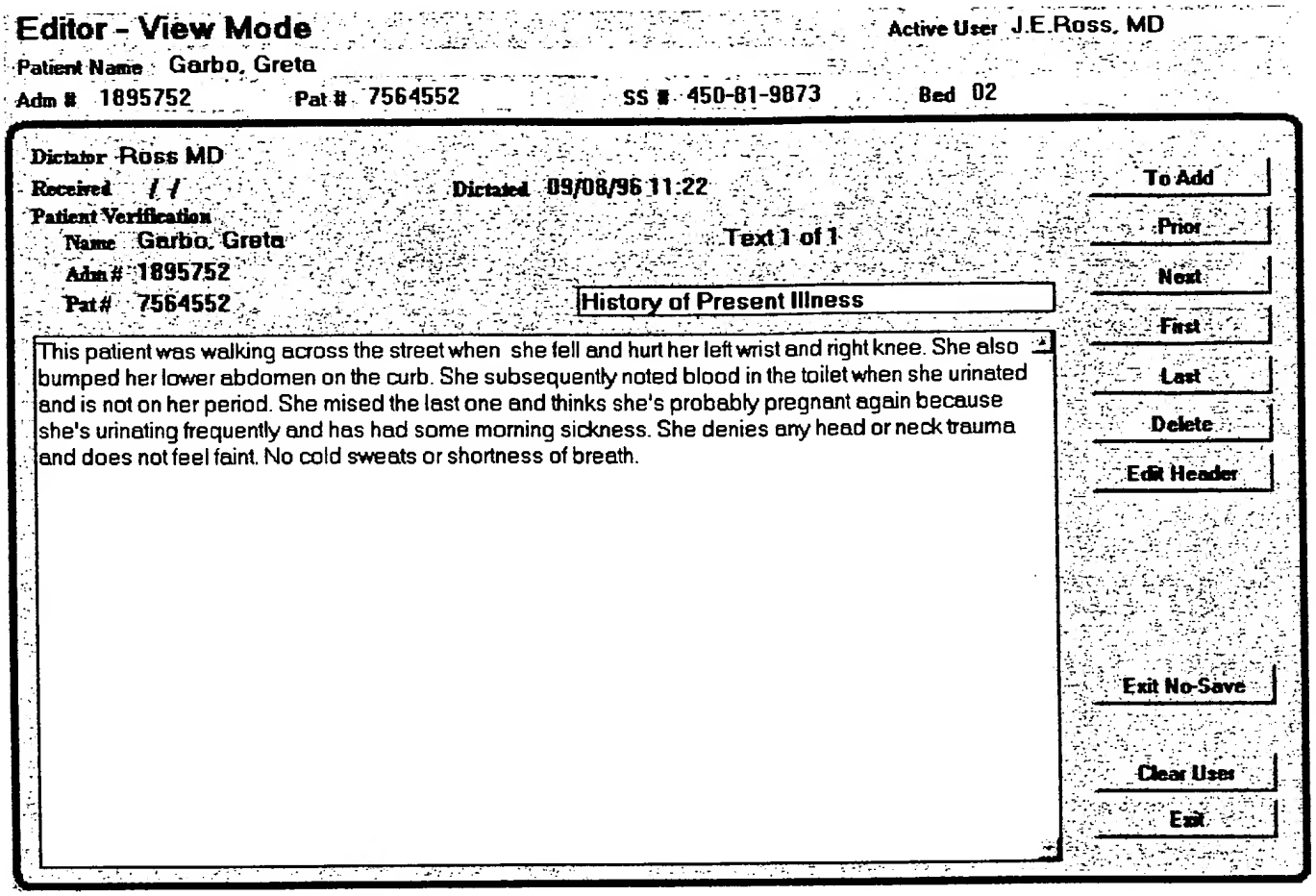

Figure Chapter 2: -14: Editor-View Mode

(Image: editor-view-mode.bmp)

If you wish to augment the record with dictation, TeleMed automatically integrates your dictation into the record.

Chapter 3: Getting Results With TeleMed

This chapter describes how to use TeleMed's data entry, retrieval and output functions.

TeleMed System Overview (All Users)

TeleMed System Security

The TeleMed system provides a security validation function. Personnel using the system must clearly demonstrate their identity using single and multiple passwords (ex. applying an electronic signature requires a second password) depending on the system configuration. The user's identity establishes the individual's "right" to use various functions. For example, physicians may be the only users given rights to generate prescriptions, nurses could have rights to implement various medical procedures, ward clerks might need rights to order labs, but records clerks may be limited to changing demographic information. After a certain period of inactivity, terminals revert to a "locked" status which requires re-entry of passwords, etc. in order to function.

Logging onto TeleMed

TeleMed is configured to automatically start up when any bedside workstation boots-up (starts-up). If TeleMed has been shut down or your workstation is not set to automatically start TeleMed on boot-up, TeleMed can be re-started by double clicking the TeleMed Desktop Icon or by selecting it from the "Start" Menu at the lower left of your screen.

If you have the TeleMed Smartcard Option:

TeleMed's Smartcard option allows users to quickly log in and out of TeleMed with a credit card like device on which is stored your username and opening password.

- To log into TeleMed, insert your personalized Smartcard in the reader slot. TeleMed will validate your username and password open to the Active Patient List in which you will see your ED's "grease board" (reference Figure Chapter 3: -2: Active Patient List (main tracking screen) Highlights).

- To log out of TeleMed, extract your Smartcard from the reader, the system would complete any remaining operations and close down to a protect screen or screen saver.

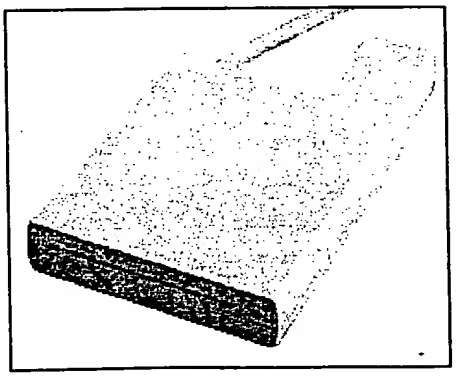

Figure Chapter 3: -1: Smartcard Reader

(Image: smartcard.bmp)

If you *do not have* the TeleMed Smartcard Option:

When TeleMed is started, it opens its Start-up Screen. If you are a registered user of TeleMed, your name will be placed on one of the user buttons. If you are required to use TeleMed and your name does not appear on this screen, contact your local TeleMed System Manager.

- To manually log into TeleMed, click on your name. You will be prompted for your password. Enter your password. TeleMed will validate your username and password then it opens the Active Patient List in which you will see your ED's "grease board" (reference Figure Chapter 3: -2: Active Patient List (main tracking screen) Highlights).

- To manually log out of TeleMed, click on the "Exit" button at the lower right corner of the TeleMed screen to save any information entered on the active screen and then click on the "Clear User" button located above the "Exit" button.

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TeleMed Main Tracking Screen

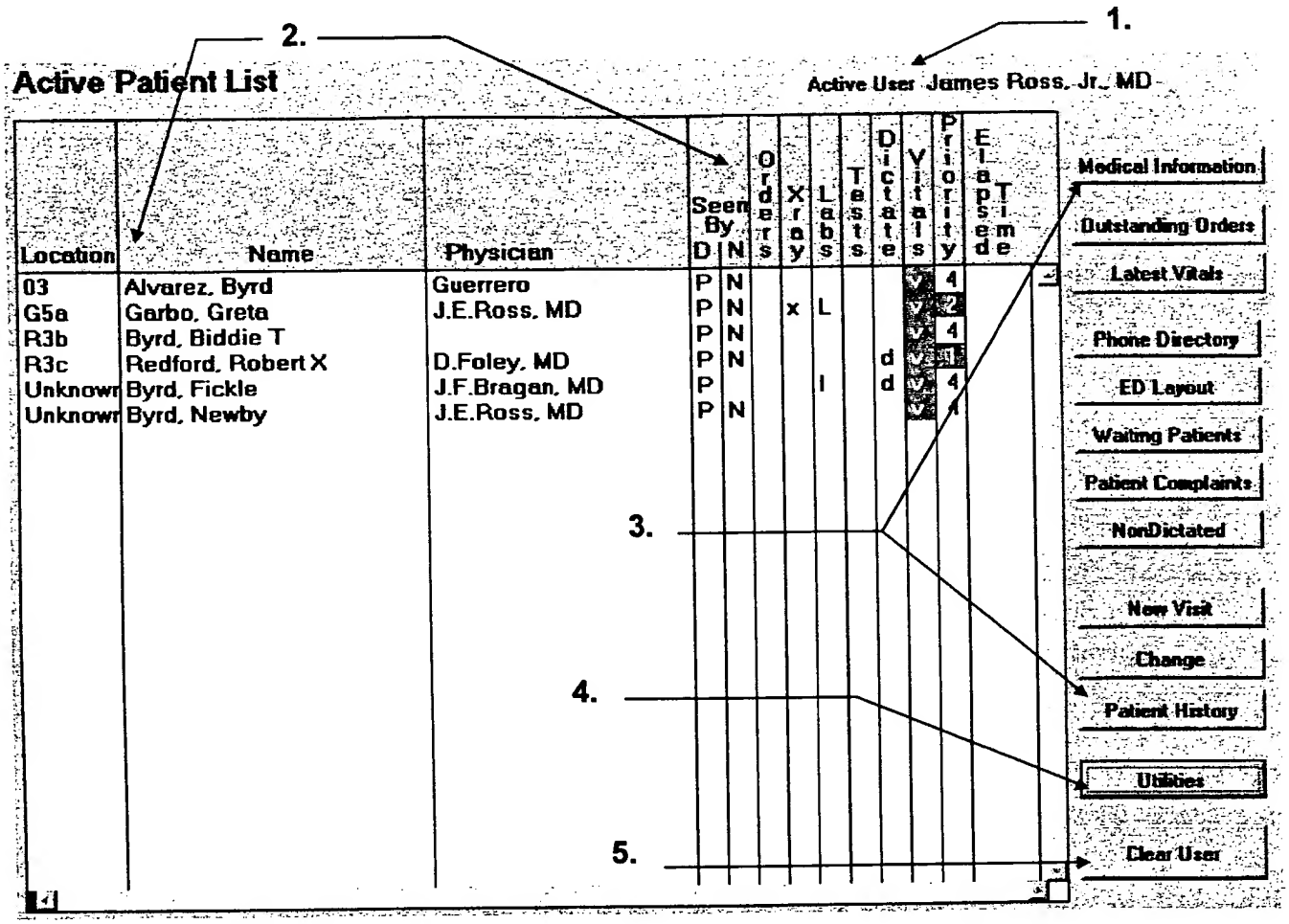


Figure Chapter 3: -2: Active Patient List (main tracking screen) Highlights

(Image: tm-2.bmp)

The "Active Patient List" provides you with quick access to a high level summary of your Emergency Department's current state. It is your Emergency Department's "main tracking screen" through which TeleMed helps you manage your ED.

It quickly answers the question: "What is happening in your ED?"

I.E...

- Who is here?
- Who is next?
- What are their vitals?
- Who should be made next?
- Where are they?
- How do I get there?

This "Active Patient List" screen performs five functions:

1. Identifies the "Active User" (upper tight corner of screen) logged into TeleMed at this work-station. This person should be you.
2. Provides a "Grease Board" listing:
    - Patient Location (within Emergency Department)
    - Patient Name
    - Attending Physician
    - Patient Priority
    - Color Coded Patient Order Status (refer to the following Grease Board Color Codes)
3. Provides access to clinician and patient information functions (right side of screen, buttons: "Medical Information" through "Patient History").
4. Provides access to System Management "Utilities" (right side of screen).
5. Provides user log-out function (lower right button: "Clear User").

Clicking on any button, other than the "Utilities" and "Clear User" buttons, will allow you to review, enter or modify patient information.

The "Clear User" button will log you out of TeleMed.

Clicking on the "Utilities" button will allow those with System Manager privileges to:

- Edit, add or delete users
- Edit the doctor drug prescription preference list
- Edit doctor drug order preferences (medications ordered to be given in ED)
- Edit Prephrased text

Grease Board Color Codes

- Black letters on Yellow -- No Alert
- Black letters on White -- Ordered
- White letters on Green -- Partially Filled or Back
- White letters on Peach -- Late
- White letters on Red -- Alert, Action Required
- White letters on Black -- All Are Filled or Back

TeleMed Main Patient Information Screen

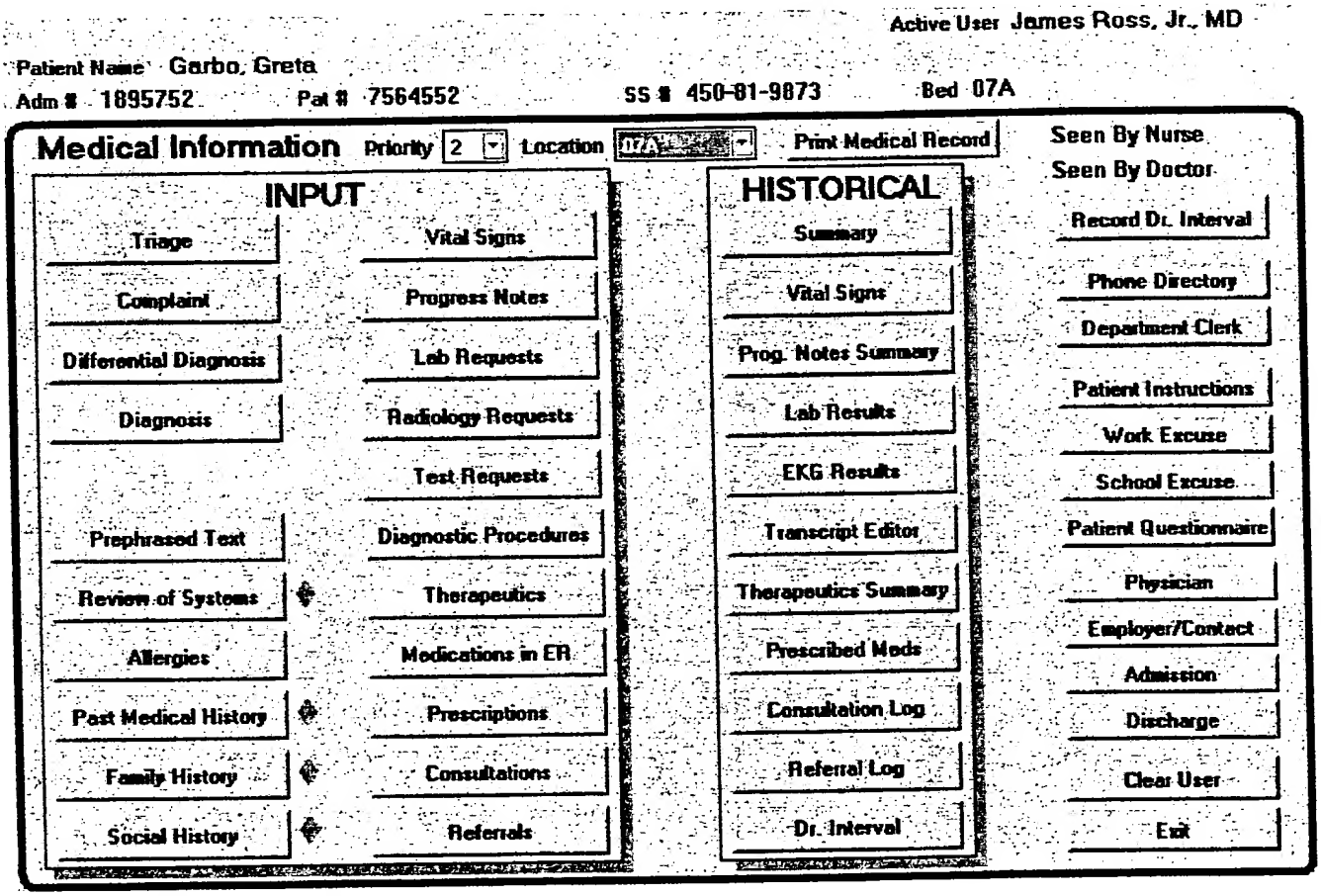


Figure Chapter 3: -3: Medical Information (main patient information screen)

(Image: medical-info.bmp)

The Medical Information screen displays the full range of TeleMed options, from entering complaints and diagnoses to writing prescriptions or printing work excuses, with which to medically document your patient.

Please note, there are 2 sides to the Medical Information screen.
One area is **INPUT.** All of the buttons in this section/box are for you to enter information in the patient's chart.
The other side is **HISTORICAL.** The buttons in this section/box allow you to review information entered in the patient's chart.

With a single touch of the screen, you can move painlessly through other screens to:

- capture a patient's history, enter vital signs, prescribe medications or give orders to others
- access/review recent and past patient's summaries, vitals, therapeutics, consultations and referrals.

Treat this as your main patient information screen.
It quickly answers "What is happening with your patient?".

General TeleMed Usage (All Users)

Mouse & Keyboard

Using a mouse is usually easier and quicker than using a keyboard. Because of this, most procedures accomplished via TeleMed are done with a mouse (or touch screen if you have purchased that option).

Whenever you are instructed to "***Click***" on a TeleMed item/function, you will place the tip of the screen pointer of your mouse over that item and quickly press and release the left mouse button. Whenever you are instructed to "***Double-click***" on an item, you will place the tip of the screen pointer of your mouse over that item and "click" the left mouse button twice in rapid succession.

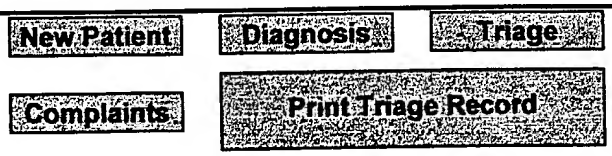
Keyboard usage is limited to the entering & deleting text in form fields (dialogue boxes) provided within TeleMed.

Touch Screen (optional)

With the Touch Screen option, users should equate "***Click***" to "***One Touch***" and "***Double-click***" to "***Two Touches***" in rapid succession.

Navigating / Changing Screens

TeleMed offers four methods to navigate (or change) to/from function screens. All navigation is performed via on screen buttons:

1. Specific function buttons Examples	 These buttons can be located anywhere on the screen.
2. Exit without saving information modified on this screen (but remain logged-in) **3. Log out and save information modified on this screen ("Clear User" always saves).** **4. Exit and save information modified on this screen**	 This button is located at lower right corner of the screen.  This button is located at lower right corner of the screen.  This button is located at lower right corner of the screen.

Using Menus

TeleMed utilizes three information menu option methods within its interface: Check box, Lists and Pull Downs. The following describes each.

Using Check box Menus

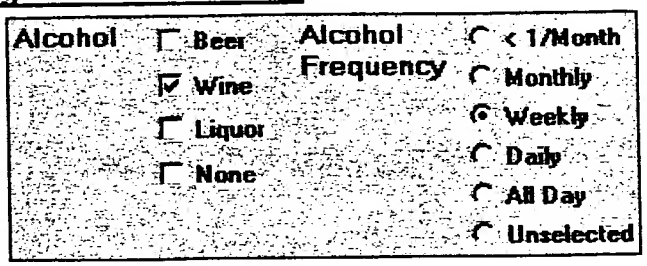


Figure Chapter 3: -4: Check box Menu

(Image: checkbox-menu.bmp)

This figure is an example of a checklist type menu. This type of menu allows the user to select multiple options, from one screen, simultaneously. Click on any check box will insert (or remove) a "✓" or "•" mark within the check box.

Some check boxes are used when only one of the listed menu options can be selected (ex. Alcohol Frequency).

Using List Menus

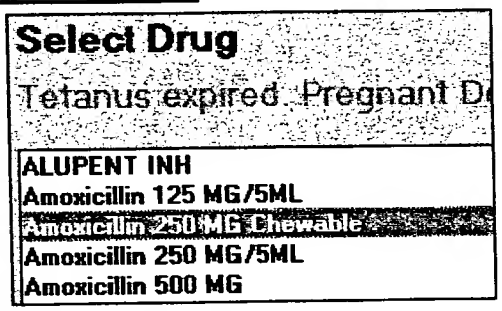


Figure Chapter 3: -5: List Menu

(Image: list-menu.bmp)

This figure is an example of a simple list type menu. This type of menu allows the user to select a single item (in this case a patient) for which additional activity will be based upon (triage, complaints, diagnosis etc.). Sometimes double clicking on a list menu item will trigger a default additional activity.

Using Pull Down Menus

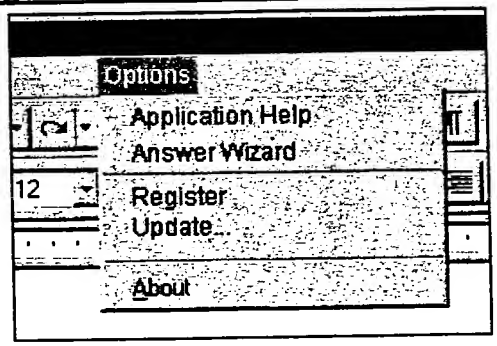


Figure Chapter 3: -6: Pull Down Menu

(Image: pull-down-menu.bmp)

This figure is a pull down (or Windows) menu that appeared when the menu bar option "Help" was selected. To open a pull down menu:

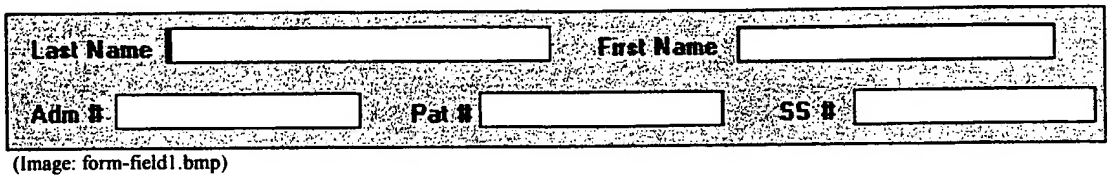
1. Move the mouse pointer so that it points to the name of the menu, and then click the left mouse button. This will pull the menu down.
2. Once the menu has been selected, click the menu item you want.

TeleMed uses very few of these.

Entering & Deleting Text In Form Fields (Dialogue Boxes)

The following screens are examples of the two types of form fields used in TeleMed.

The first sample of form fields (Last Name, Adm. #, etc) are examples of single line form fields. The second sample is an example of a multiline form field as used in "Edit View Mode".



(Image: form-field1.bmp)

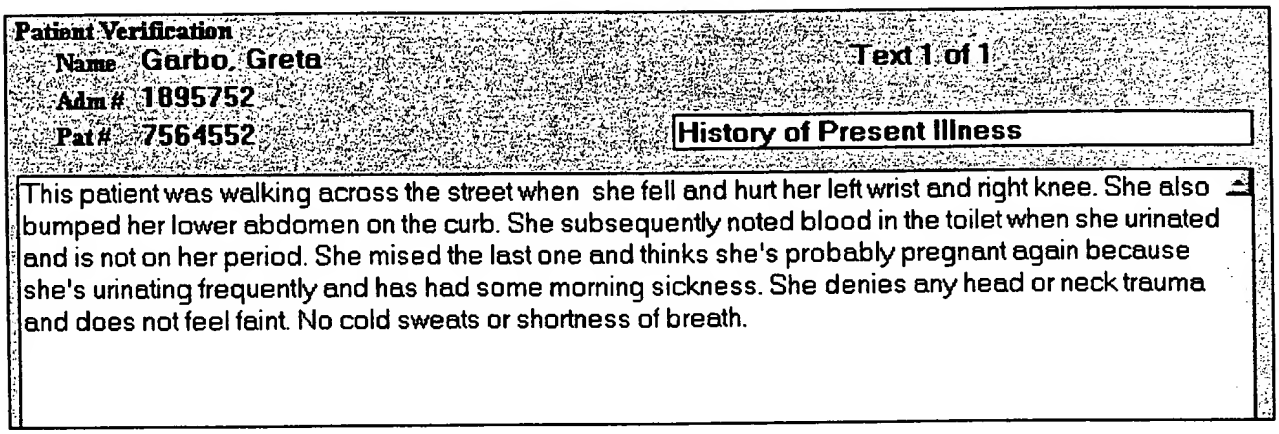


Figure Chapter 3: -7: Typical Form Fields

(Image: form-field2.bmp)

TIPS:

- Before you can enter text in a form field, make sure it is made active by placing your mouse pointer over the field and clicking your mouse once. An active field will have a blinking " I " vertical cursor in it.
- Using the "Tab" key to switch between form fields allows you to work with just the keyboard and not have to switch to your mouse to move to another form field.

Printing

Medical records are sent to your local printer when the "Print Medical Record" button is selected in the Medical Information screen (refer Figure Chapter 1: -1, just above HISTORICAL field). The "Print Medical Record" button will open TeleMed's "Patient Record Generator" screen from which you can print the following:

- Nursing Record
- Triage Record
- Dictation Record
- Financial/Insurance Record
- Final Patient Record
- Interim Patient Record

TeleMed Tracking System (All Users)

Overview

TeleMed assists you with managing your ED. The hub of these tasks is the "Active Patient List" screen. This section will focus on the ED tracking / management functions.

Alerts and Checks

TeleMed provides "medical condition" alerts and automatically places these where pertinent. For example x-ray orders on pregnant women include a "shield abdomen" warning. Drug allergies are listed in medication ordering and administration sections.

The following graphical symbols are used:

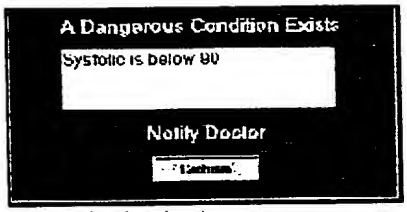
Symbol	Description	Usage
✓	Red Check	Used to indicate that this TeleMed function has not been opened for this patient and no data has been entered
◆	Red Diamond	Used to indicate that this TeleMed function has been opened for this patient. Once opened, the user can opt to not enter data and the diamond will appear upon exit
 (Image: alert-icon.bmp)	Red Screens	A red screened window will pop up when certain type data is entered that requires immediate attention. **Example:** Vital signs are entered that are outside a specified "acceptable" range (ex. BP=50/20). Upon exiting the Vitals screen, a red pop-up window will open alerting the user to immediately contact a doctor

Table Chapter 3: -1: Alerts and Checks

Calling Up the "Grease Board"

1. Log into TeleMed (refer to Logging onto TeleMed, page 29) to open the "Active Patient List". The "Grease Board" is located on this screen.

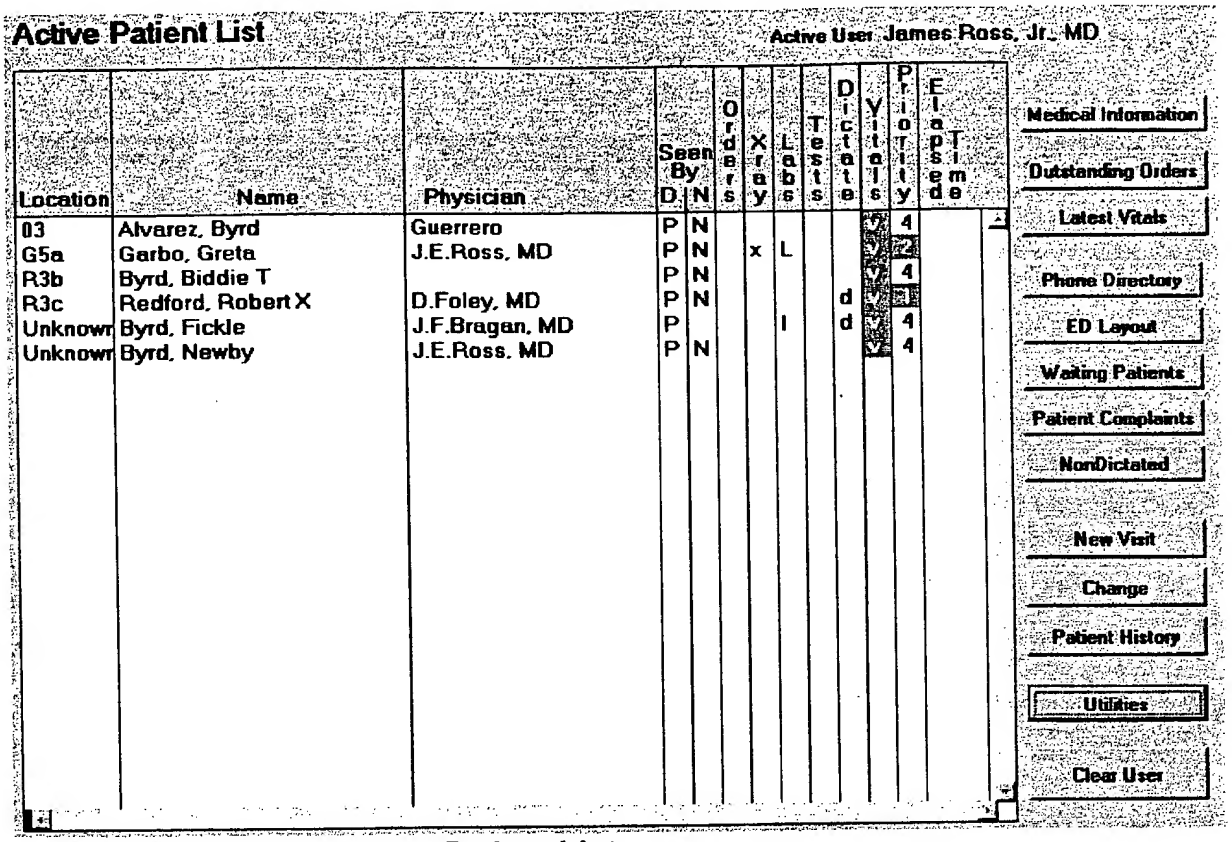


Figure Chapter 3: -8: Active Patient List

(Image: tm-2.bmp)

2a. Select patient from Active Patient List by clicking on name then click the Medical Information button to update patient information.

or

2b. Double Click the patient name in the Active Patient List to update patient information.

Either of these actions will open the Medical Information screen (refer to page 16, Medical Information (Main Patient Information Screen)).

Alternate access to this screen:

- Patient Order List *or* Patient Complaint List

Viewing Patients on the ED Graphic Layout

From the "Active Patient List" (your main tracking screen):

ED Layout

1. Click the Ed Layout button.

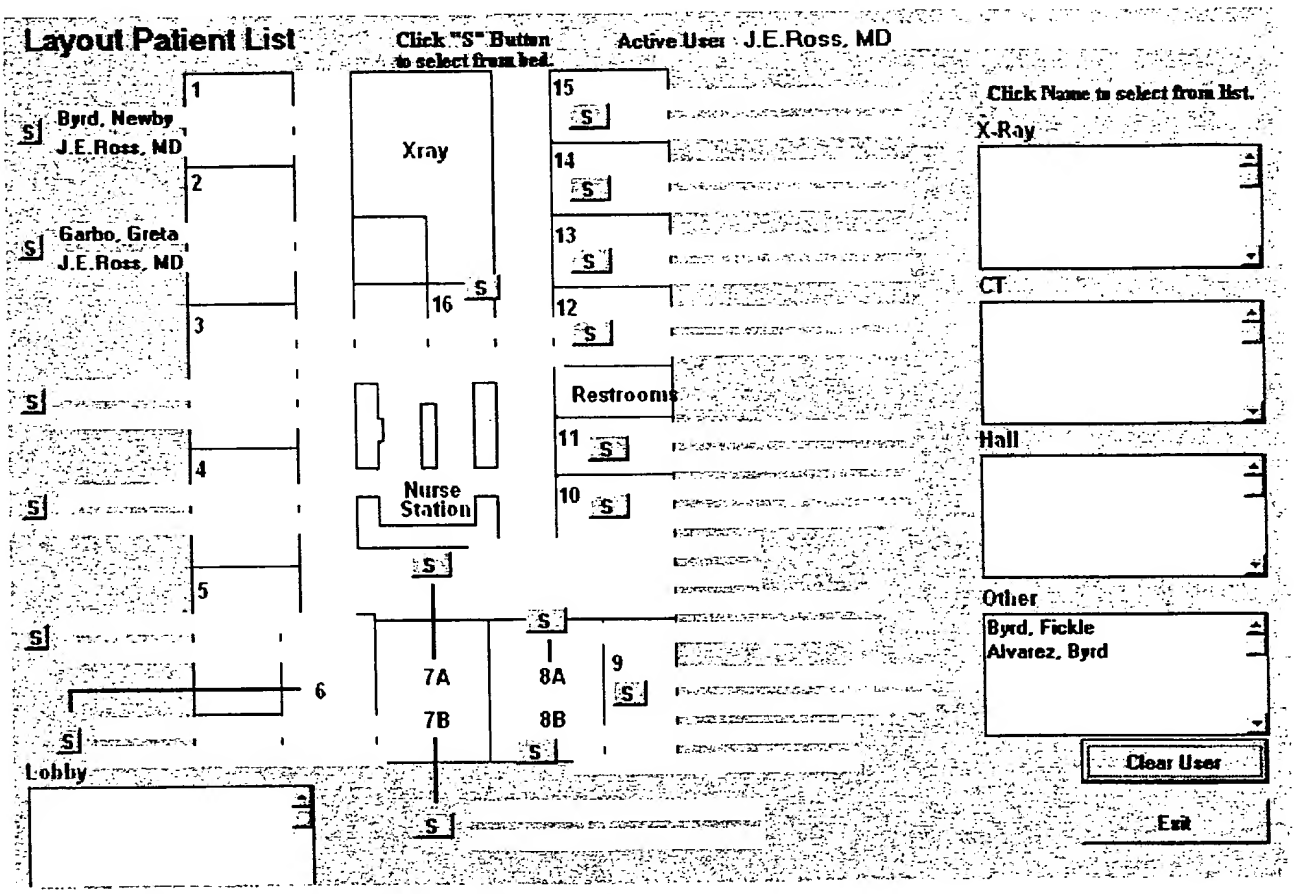


Figure Chapter 3: -9: Layout Patient List

(Image: layout-patient-list.bmp)

S

2a. Click the S button next to the patient who's information you wish to update.

or

2b. Double Click the name you wish to update in the listed menus (Lobby, X-Ray, CT, Hall, Other).

Either of these actions will open the patient's Medical Information screen (refer to page 16, Medical Information (Main Patient Information Screen)).

Alternate access to this screen:

- Patient Order List *or* Patient Complaint List

Viewing Patients In the ED by Complaint

From the "Active Patient List" (your main tracking screen):

Patient Complaints

1. Click the Patient Complaints button.

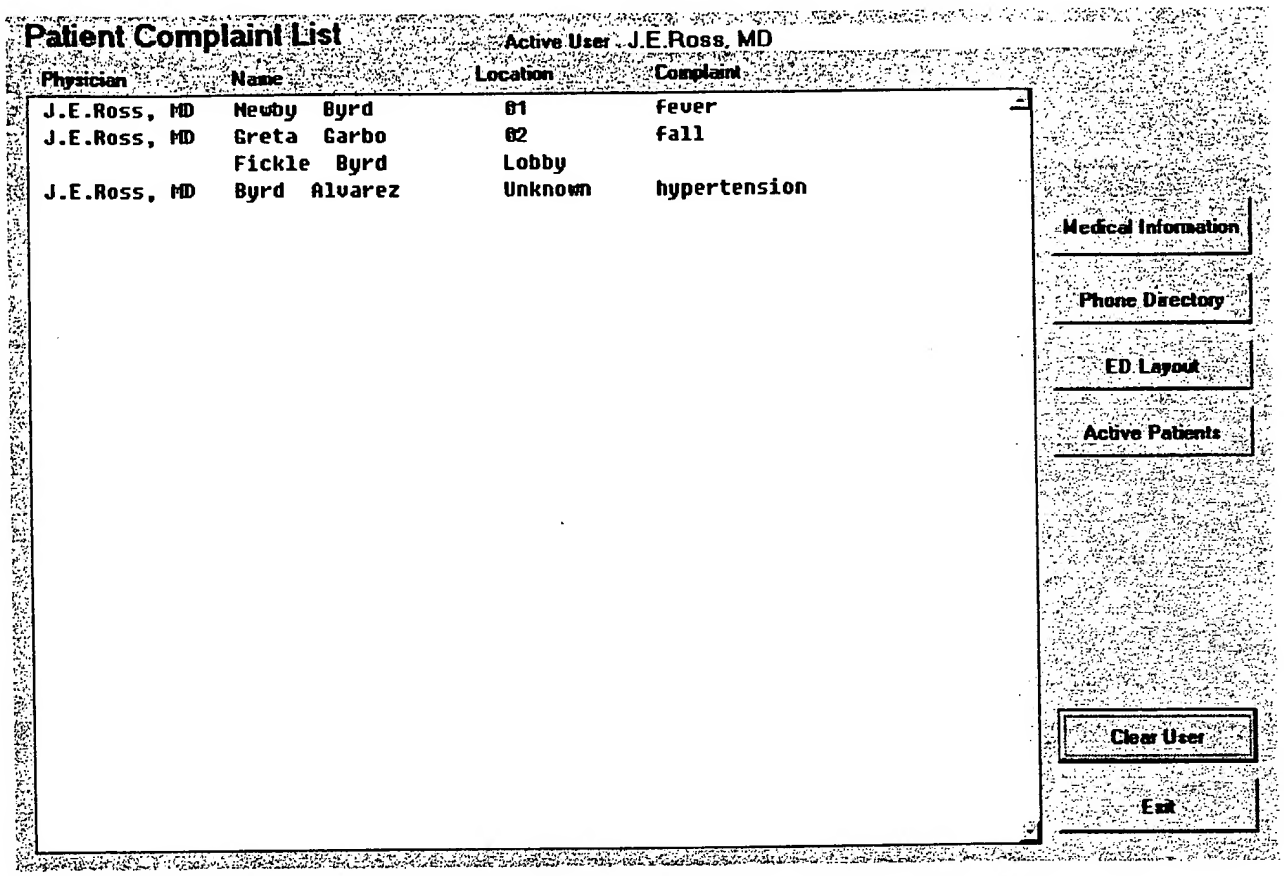


Figure Chapter 3: -10: Patient Complaint List

(Image: patient-complaint-list.bmp)

Medical Information

2a. Select patient from Active Patient List by clicking on name then click the Medical Information button to update patient information.

or

2b. Double Click the patient name in the Active Patient List to update patient information.

Either of these actions will open the patient's Medical Information screen (refer to page 16, Medical Information (Main Patient Information Screen)).

Viewing Patients In the ED Waiting to be Seen by the Doctor

From the "Active Patient List" (your main tracking screen)

Waiting Patients

1. Click the Waiting Patients button.

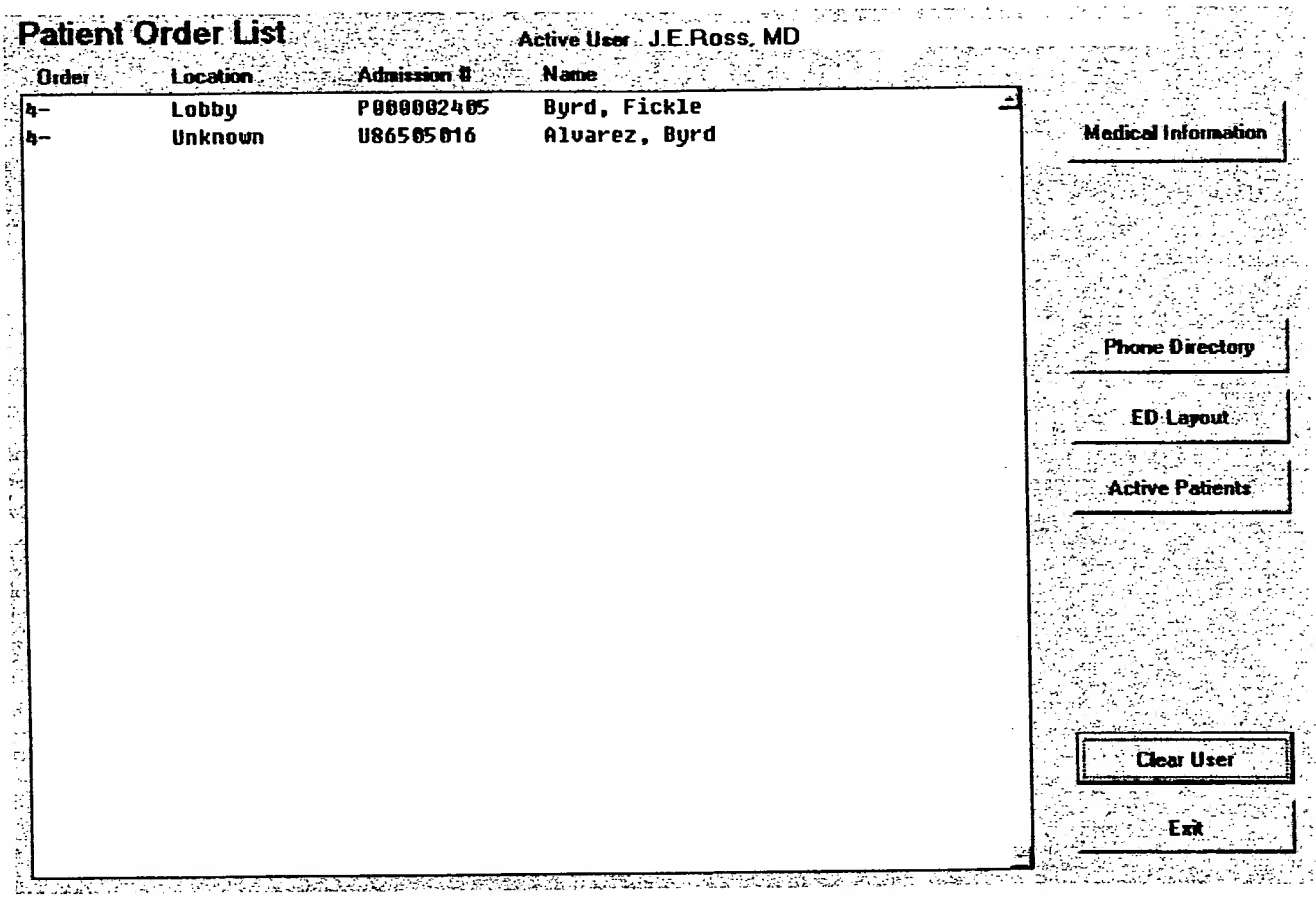


Figure Chapter 3: -11: Patient Order List

(Image: patient-order-list.bmp)

Medical Information

2a. Select patient from Active Patient List by clicking on name then click the Medical Information button to update patient information.

or

2b. Double Click the patient name in the Active Patient List to update patient information.

Either of these actions will open the patient's Medical Information screen (refer to page 16, Medical Information (Main Patient Information Screen)).

Viewing Dictation Status of Patients In the ED

From the "Active Patient List" (your main tracking screen)

1. Click the NonDictated button.

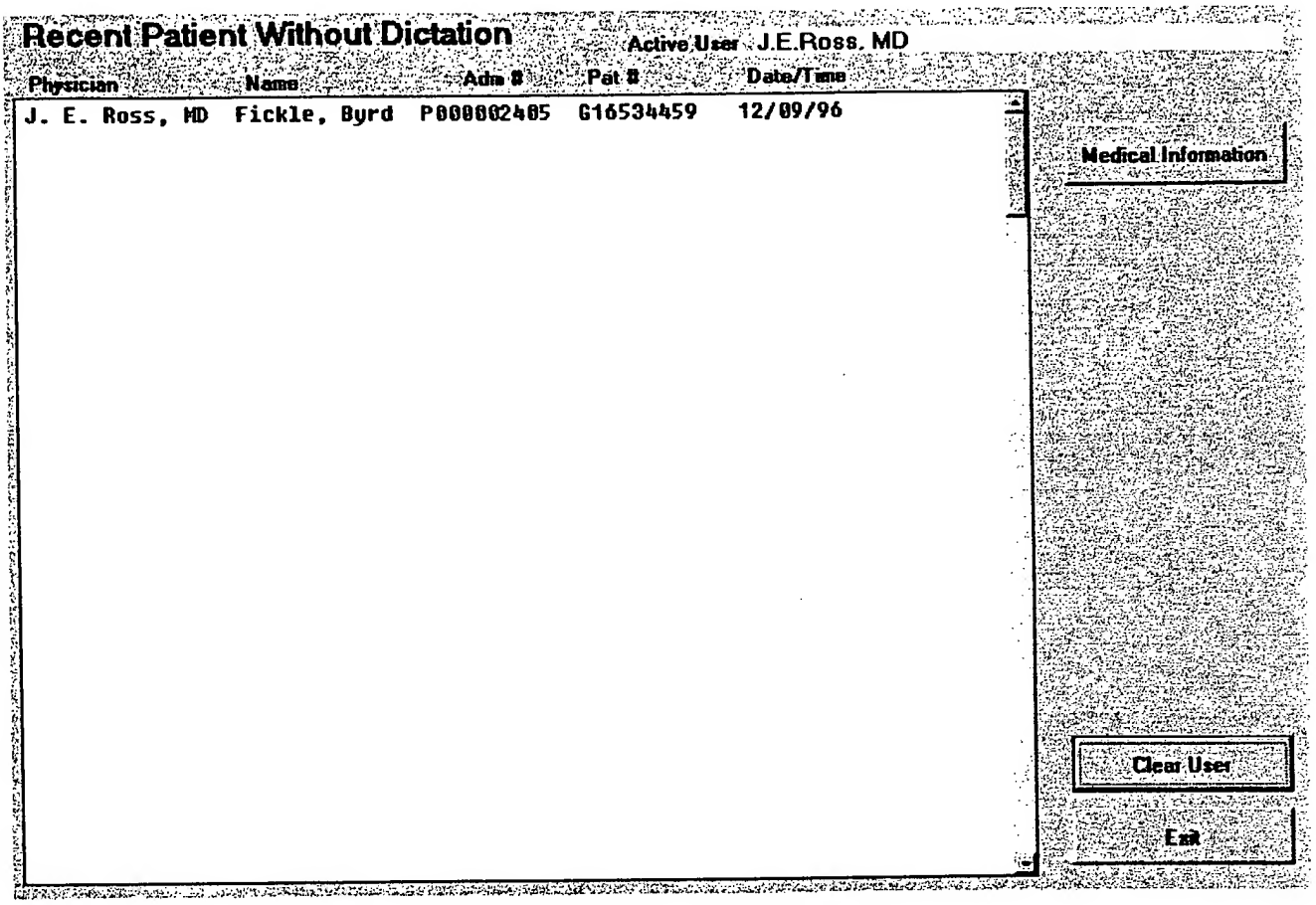


Figure Chapter 3: -12:Recent Patient Without Dictation

(Image: recent-patient-without-dictation.bmp)

2a. Select patient from Active Patient List by clicking on name then click the Medical Information button to update patient information.

or

2b. Double Click the patient name in the Active Patient List to update patient information.

Either of these actions will open the patient's Medical Information screen (refer to page 16, Medical Information (Main Patient Information Screen)).

Viewing Outstanding Orders on Patients In the ED

From the "Active Patient List" (your main tracking screen)

Latest Vitals | 1. Click the Outstanding Orders button.

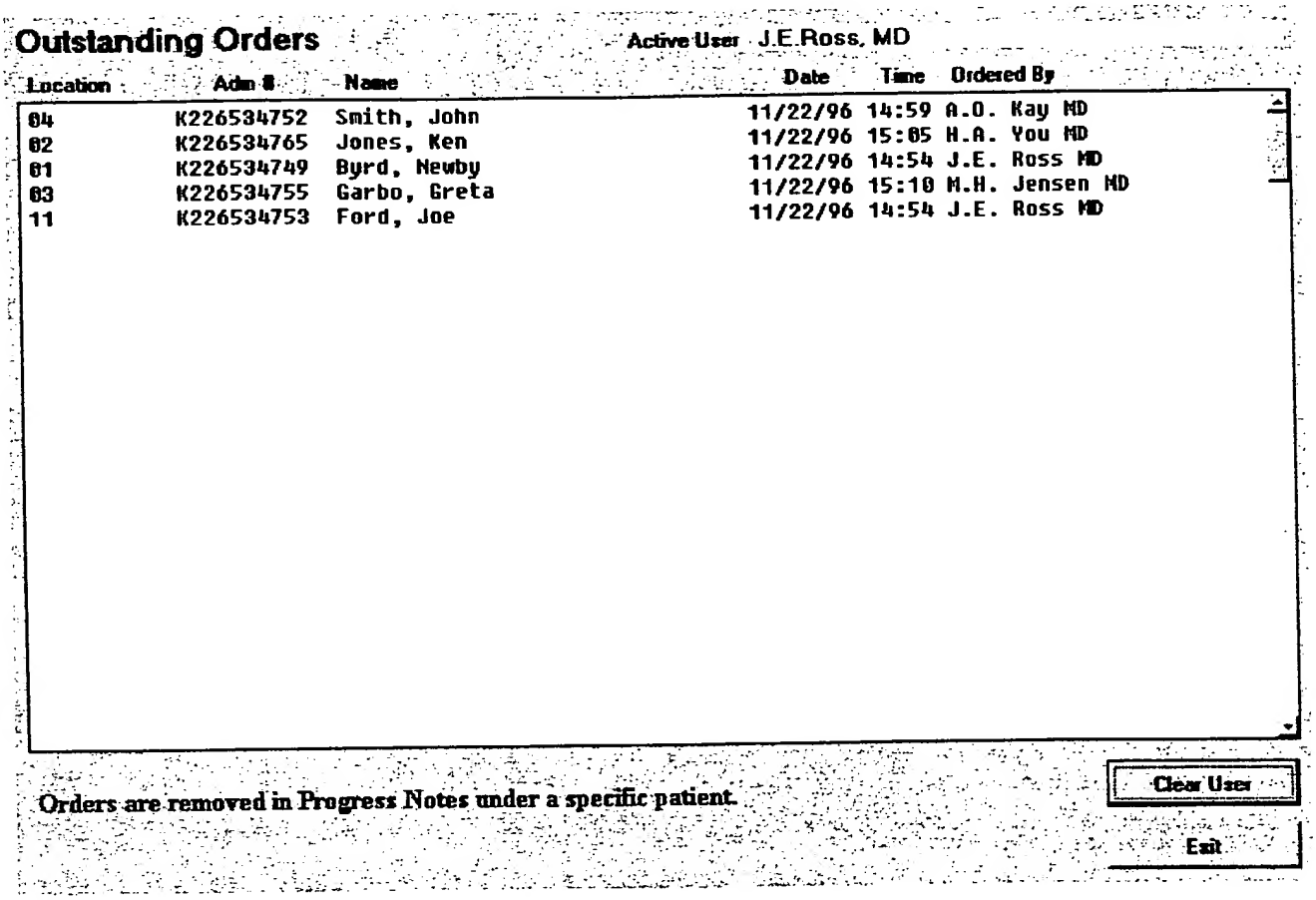


Figure Chapter 3: -13: Outstanding Orders

(Image: outstanding-orders.bmp)

Adding New Patients

Entering a New Patient Visit

From the "Active Patient List" (your main tracking screen)

1. Click the New Visit button.

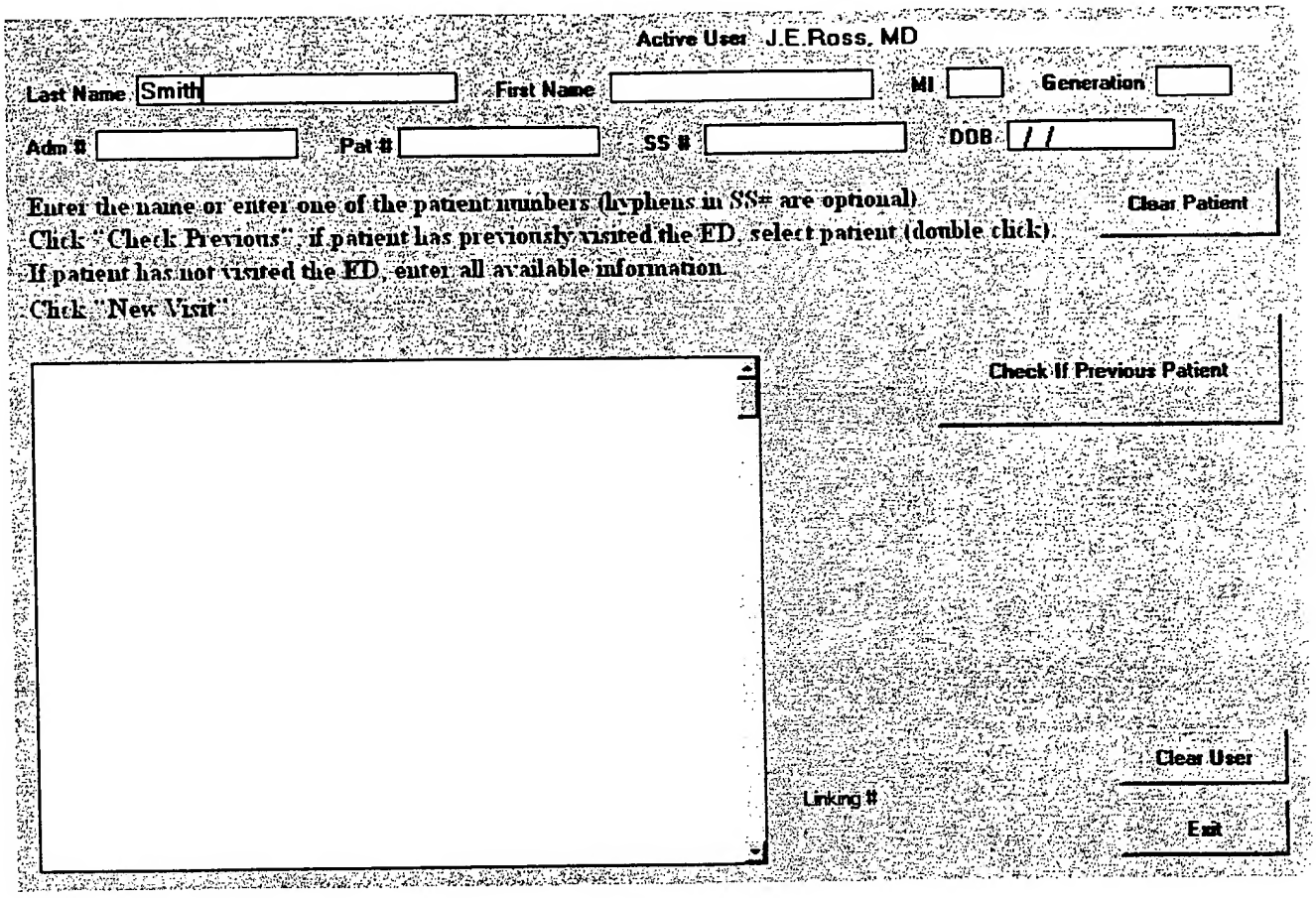
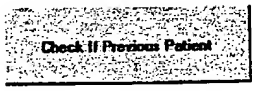


Figure Chapter 3: -14: New Visit (Patient) Entry Screen

(Image: new-visit1.bmp)



3. Enter the patient's First Name, Last Name, Middle Initial, Generation and Date of Birth (DOB).
4. Click on the Check if Previous Patient button. TeleMed will search for any previous visits by this patient that were logged into TeleMed.

Entering a New Patient Visit ---- Previous Visit Entry Found

5a. If previous visits are found, double click on the correct visit to complete the patient number (and any missing name information).

6a. Click on the New Visit button

TeleMed will now bring you to the Medical Information screen

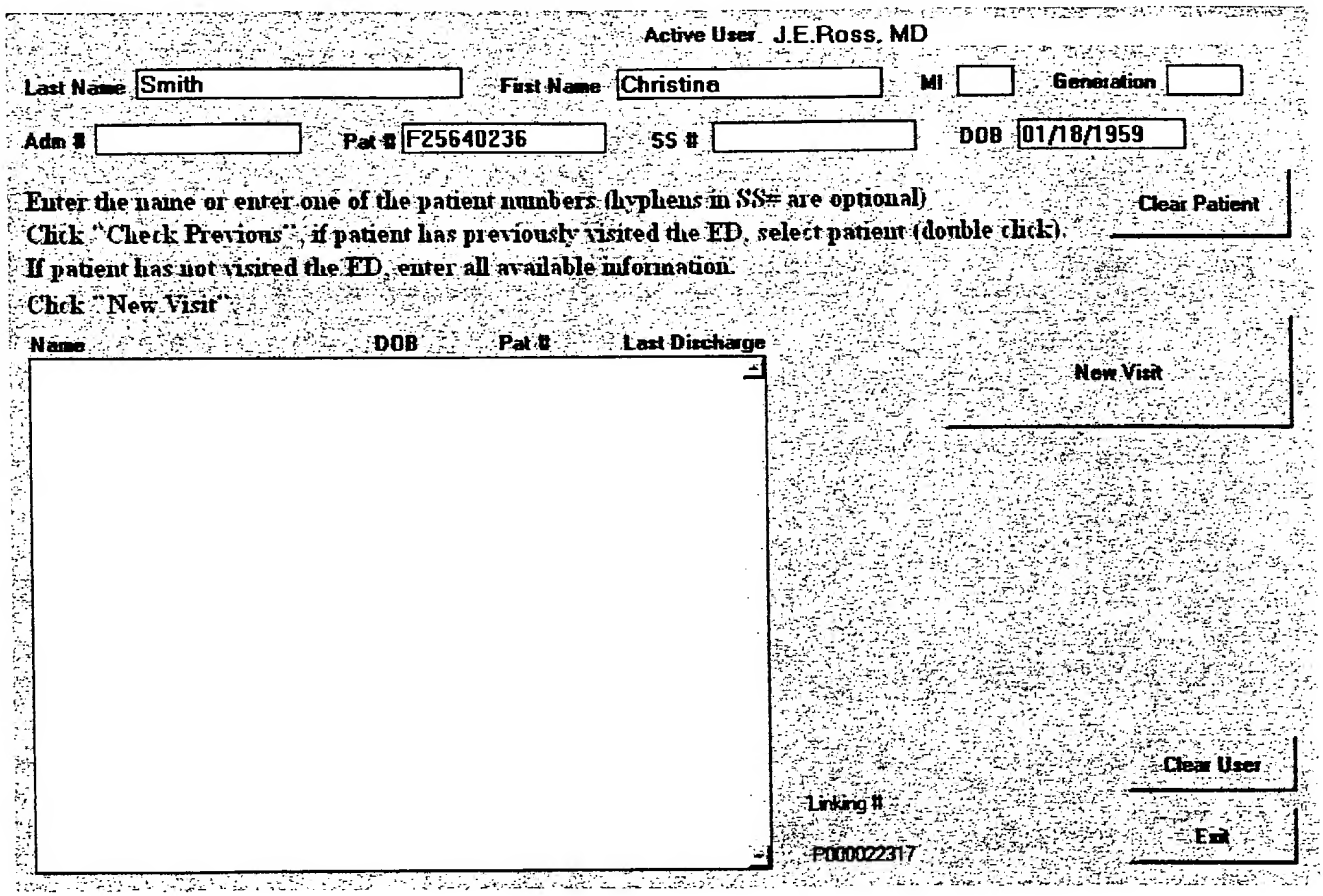
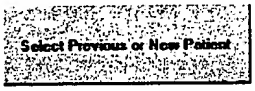


Figure Chapter 3: -15: New Visit (Patient) Entry Screen after previous visit has been selected

(Image: new-visit2.bmp)

Entering a New Patient Visit ---- No Previous Visit Entry Found



5b. If no previous visits were logged into TeleMed, the name list will remain blank.

6b. Click the Select Previous or New Patient button

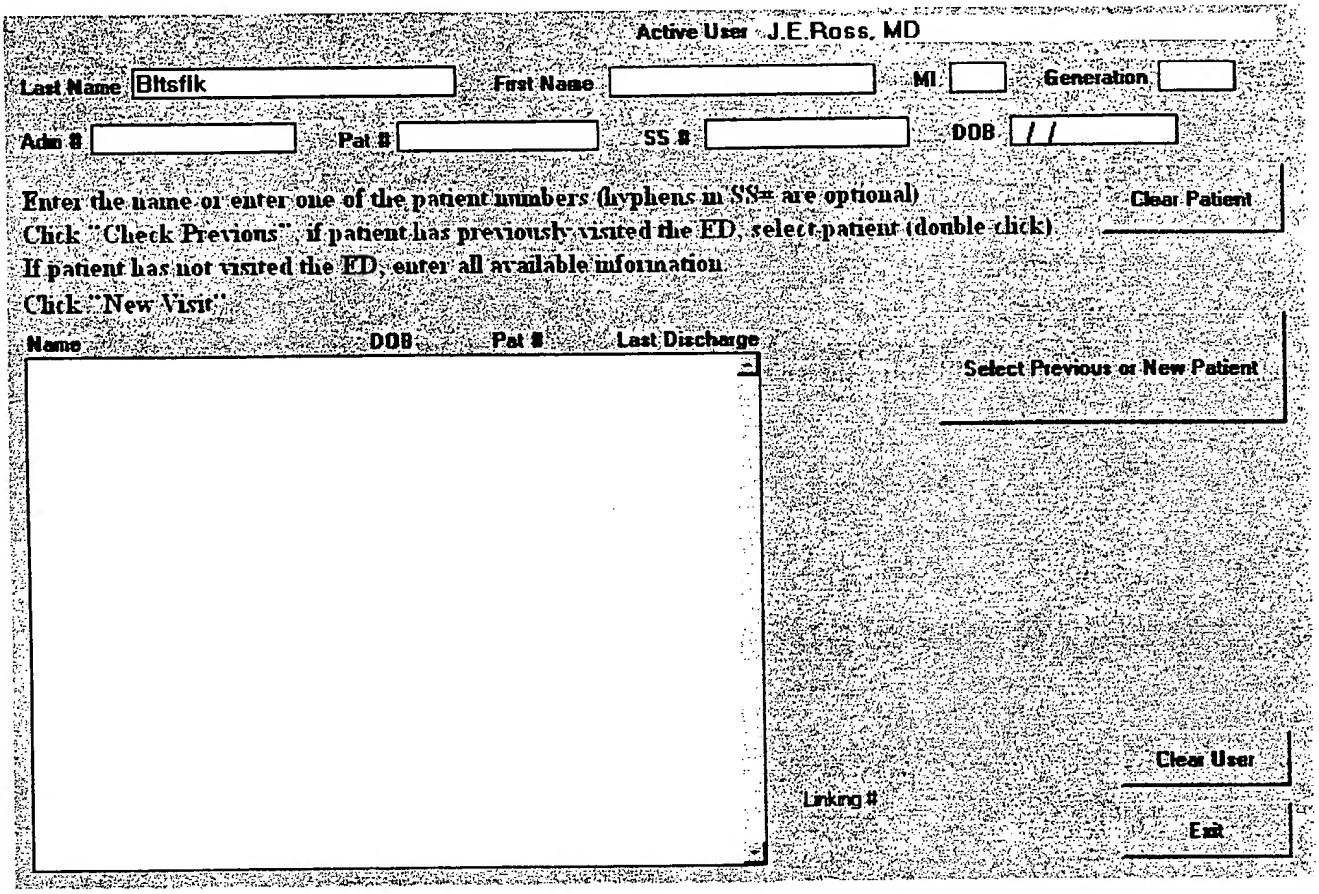


Figure Chapter 3: -16: New Visit (Patient) Entry Screen

(Image: new-visit3.bmp)

7. TeleMed will now bring you to the Medical Information screen.

Tips and Hints: Adding New Patients

- There is no need to capitalize the first letters of names or initials. TeleMed will capitalize these letters automatically.
- When entering date of birth (DOB) year information, TeleMed will automatically interpret 70 as 1970.
- The Select Previous or New Patient button can be used after entering just the last name of a patient. Note, the search results may provide a lengthy list of past patients that share the same last name. Additional name information (first name, middle initial, generation and date of birth) will provide a more concise search.

Moving Patients to Different Location

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).
2. Click the Medical Info button.
3. Click the Location pull down menu and select new location.

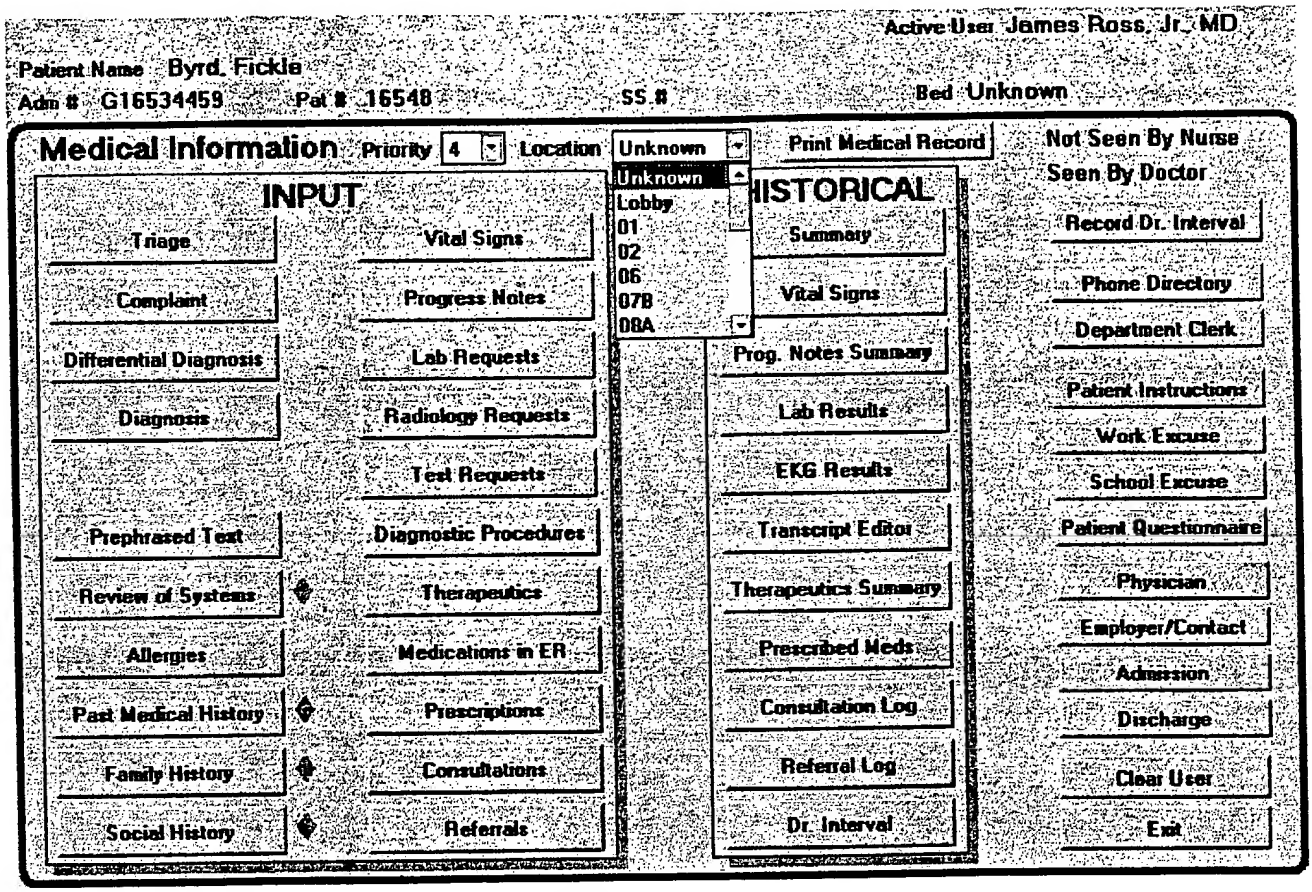


Figure Chapter 3: -17: Changing Patient Location

(Image: med-info-location.bmp)

4. Click the Exit button to save updated patient information.

Changing Acuity of Patients

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).
2. Click the Medical Information button.
3. Click the Priority pull down menu and select priority.

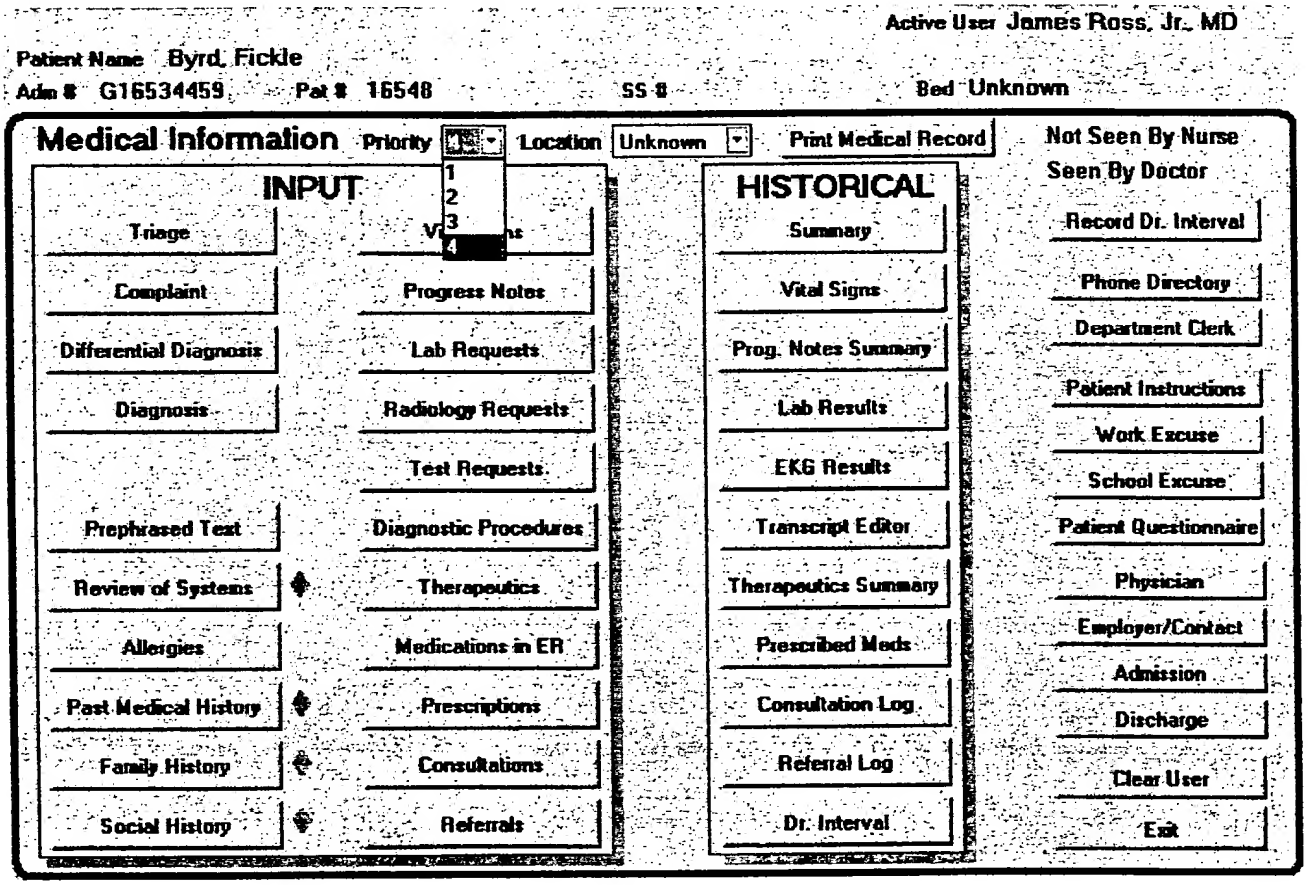
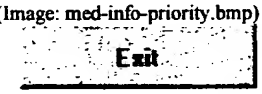


Figure Chapter 3: -18: Changing Patient Priority (acuity)

(Image: med-info-priority.bmp)



4. Click the Exit button to save updated patient information.

Modifying Patient Tracking Numbers

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).
2. Click the Change button.

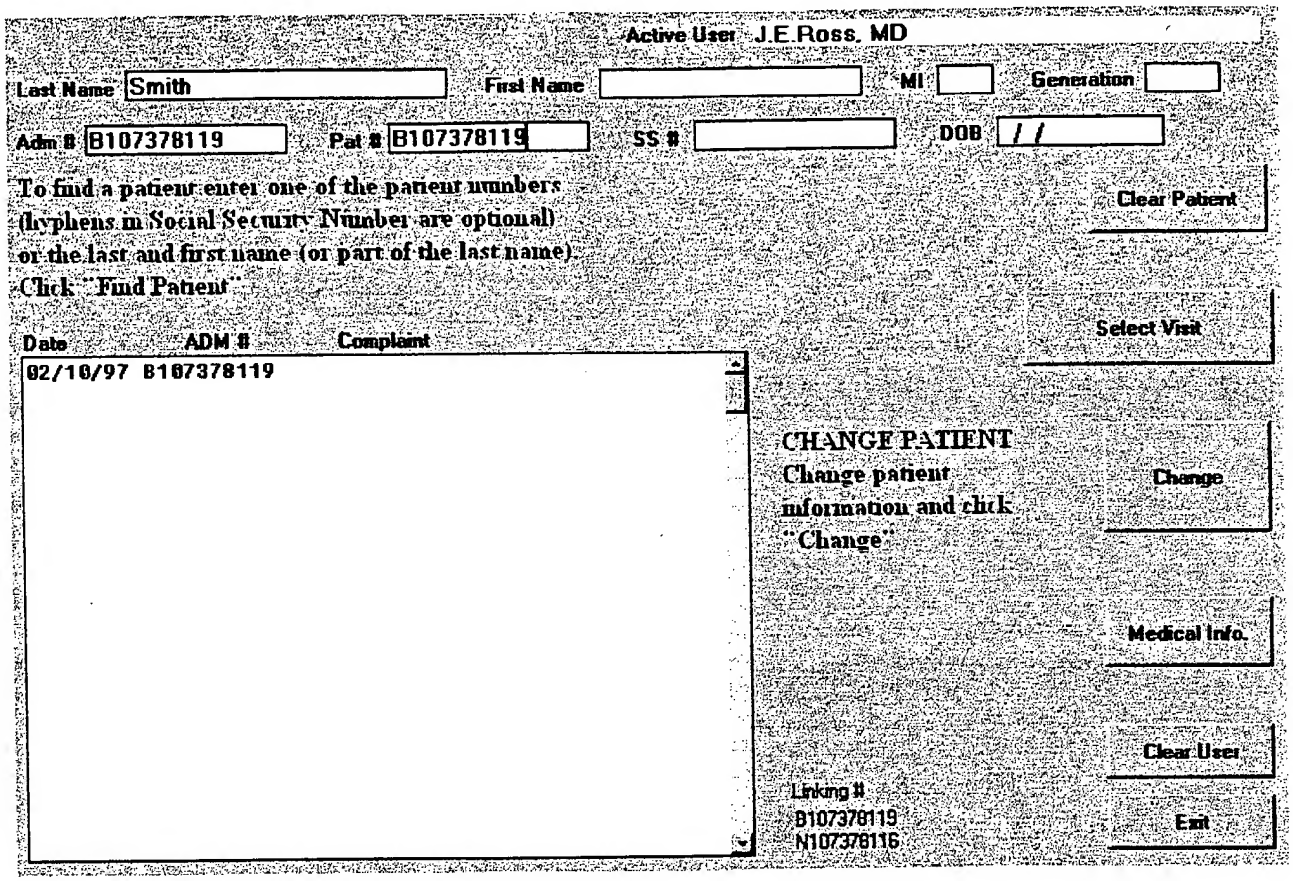
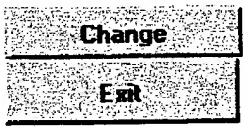


Figure Chapter 3: -19: Modifying Patient Tracking Number

(Image: change-pat-no.bmp)



3. Modify (edit) the number in the Patient Tracking number field.
4. Click the Change Button on this Screen.
5. Click the Exit button to save updated patient information.

Looking Up Previous Emergency Visits

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Patient History

3. Click on the Patient History button at the right of screen. (all prior visits to the ED will be listed)

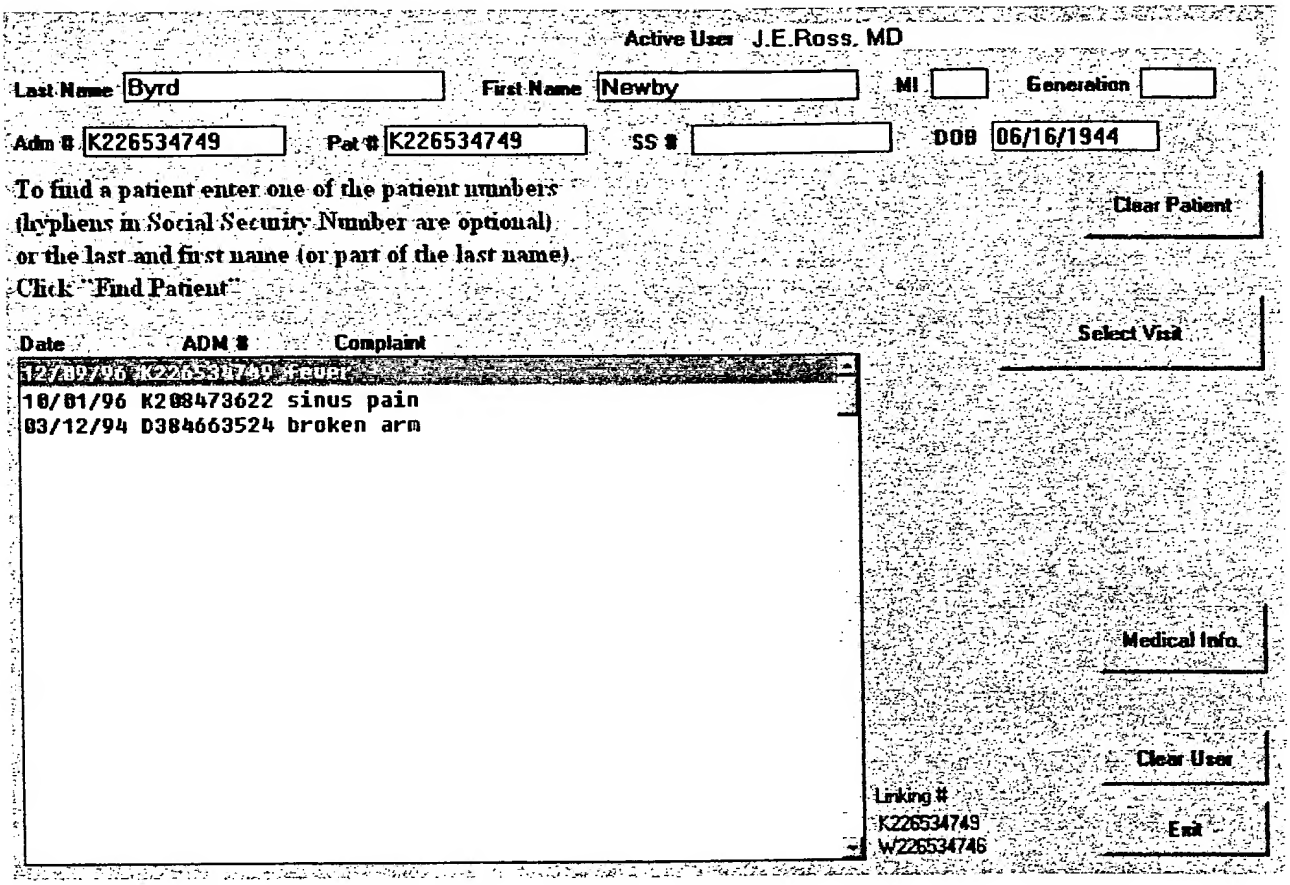


Figure Chapter 3: -20: Previous Emergency Visits

(Image: patient-history-er0358.bmp)

5. Double-click on the visit desired

Medical Information

6. Click on the Medical Info. button. (At this point, you are brought to the Medical Information Screen for the selected past ED visit.)

Click on the Summary button to review the record of that visit. (page 218)

Click on the Print Medical Record button then Print Interim Patient Record for a printout of the previous visit. (page 37)

Patient Information

Adding Patient Demographic Information (Name, Address Etc.)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Admission

3. Click on the Admission button at the right of screen.

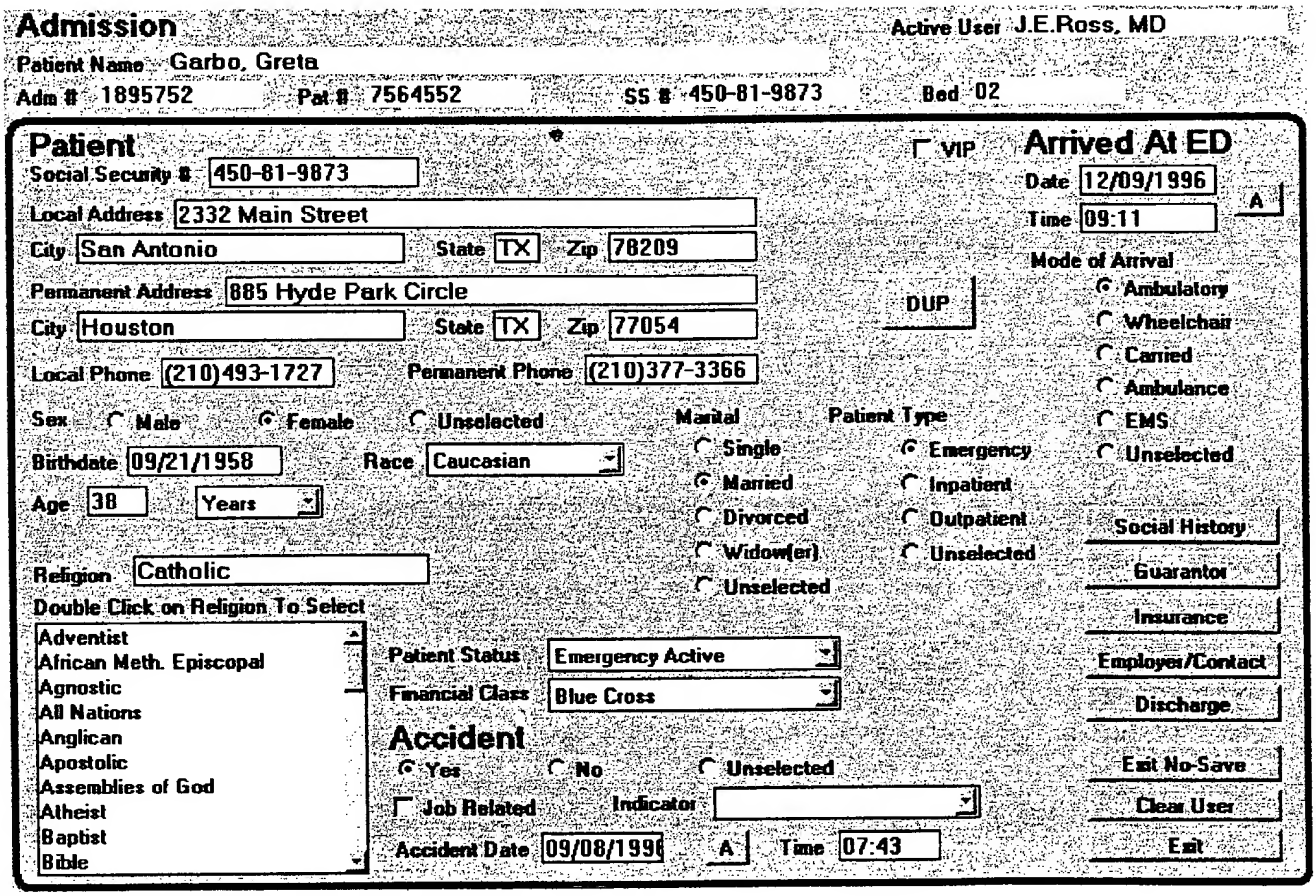


Figure Chapter 3: -21: Admission

(Image: admission.bmp)

4. Click on check boxes and form fields to complete as appropriate.

   NOTE: The DUP button allows you to duplicate the Local Address in the Permanent Address fields. The A button will automatically insert the actual (current) time and date.

Exit

5. Click the Exit button to save updated patient information.

Adding Guarantor Information

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Admission

3. Click on the Admission button at the right of screen.

Guarantor

4. Click on the Guarantor button at the right of screen.

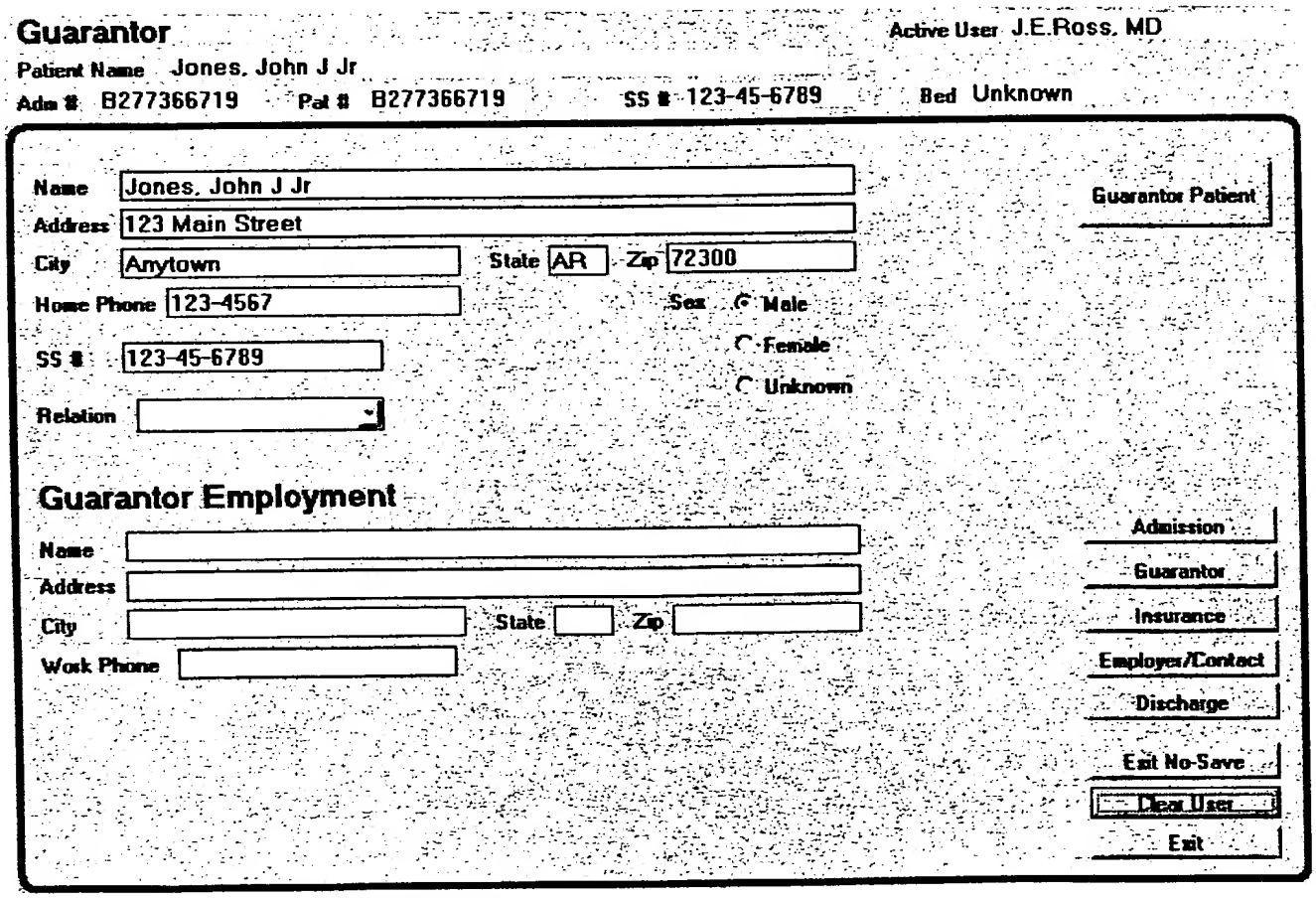


Figure Chapter 3: -22: Guarantor

(Image: guarantor.bmp)

4. Click on check boxes and form fields to complete as appropriate.

NOTE: The Guarantor Patient button allows you to duplicate the Permanent Address fields from the Admission screen.

Exit

5. Click the Exit button to save updated patient information.

Adding Insurance Information

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Admission button at the right of screen.

4. Click on the Insurance button at the right of screen.

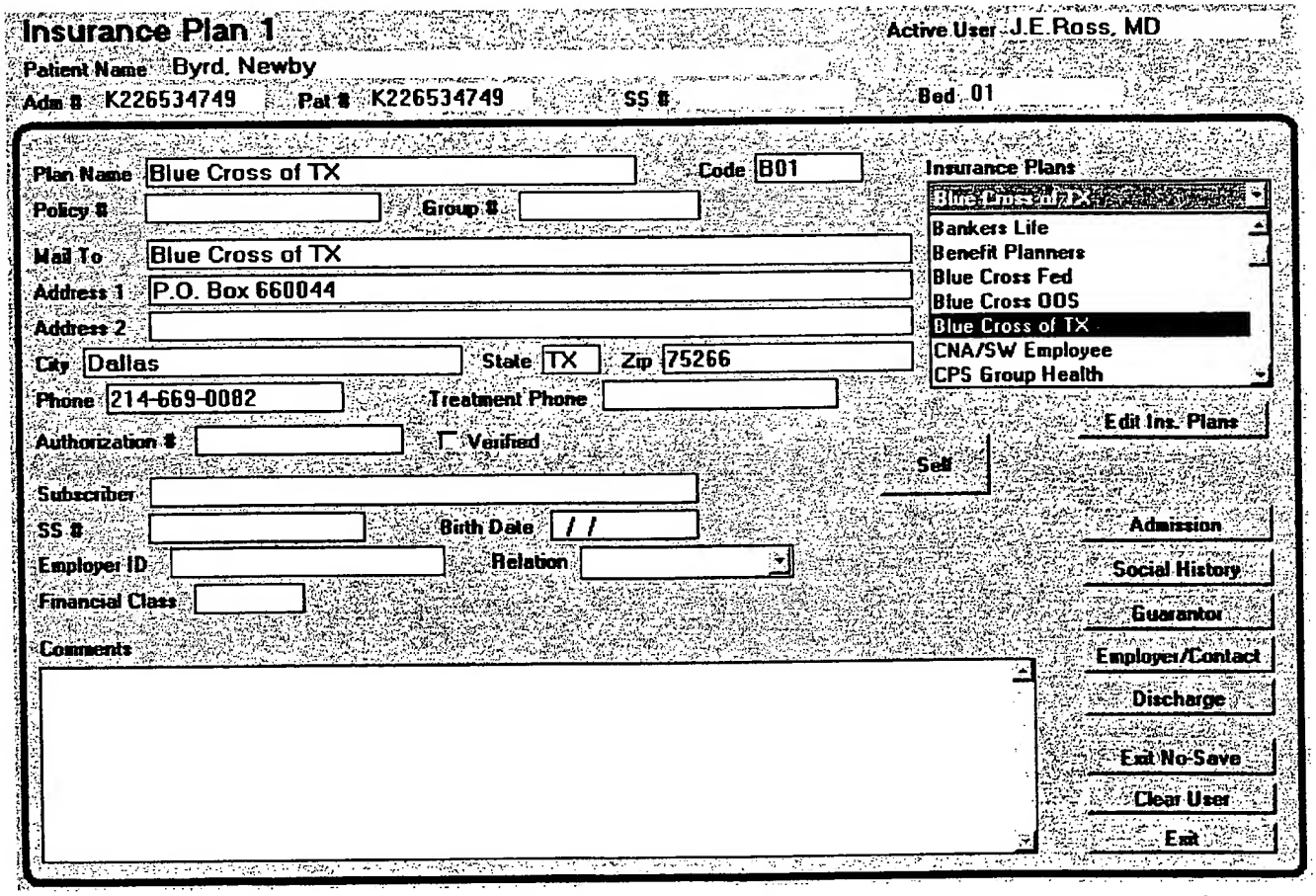


Figure Chapter 3: -23: Insurance Plan (1)

(Image: insurance-plan-1.bmp)

4. Click on check boxes and form fields to complete as appropriate.

NOTE: The Insurance Plans pull down menu lists all current insurance plans which have been entered in TeleMed. Selecting one of these will automatically load most of the fields. Click on the Edit Ins. Plans button to add new/modify plans.

The Self button allows you to duplicate any appropriate patient's information currently loaded in the Admission screen.

5. Click the Exit button to save updated patient information.

Adding Employer/Contact Information

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Employer/Contact

3. Click on the Employer/Contact button at the right of screen.

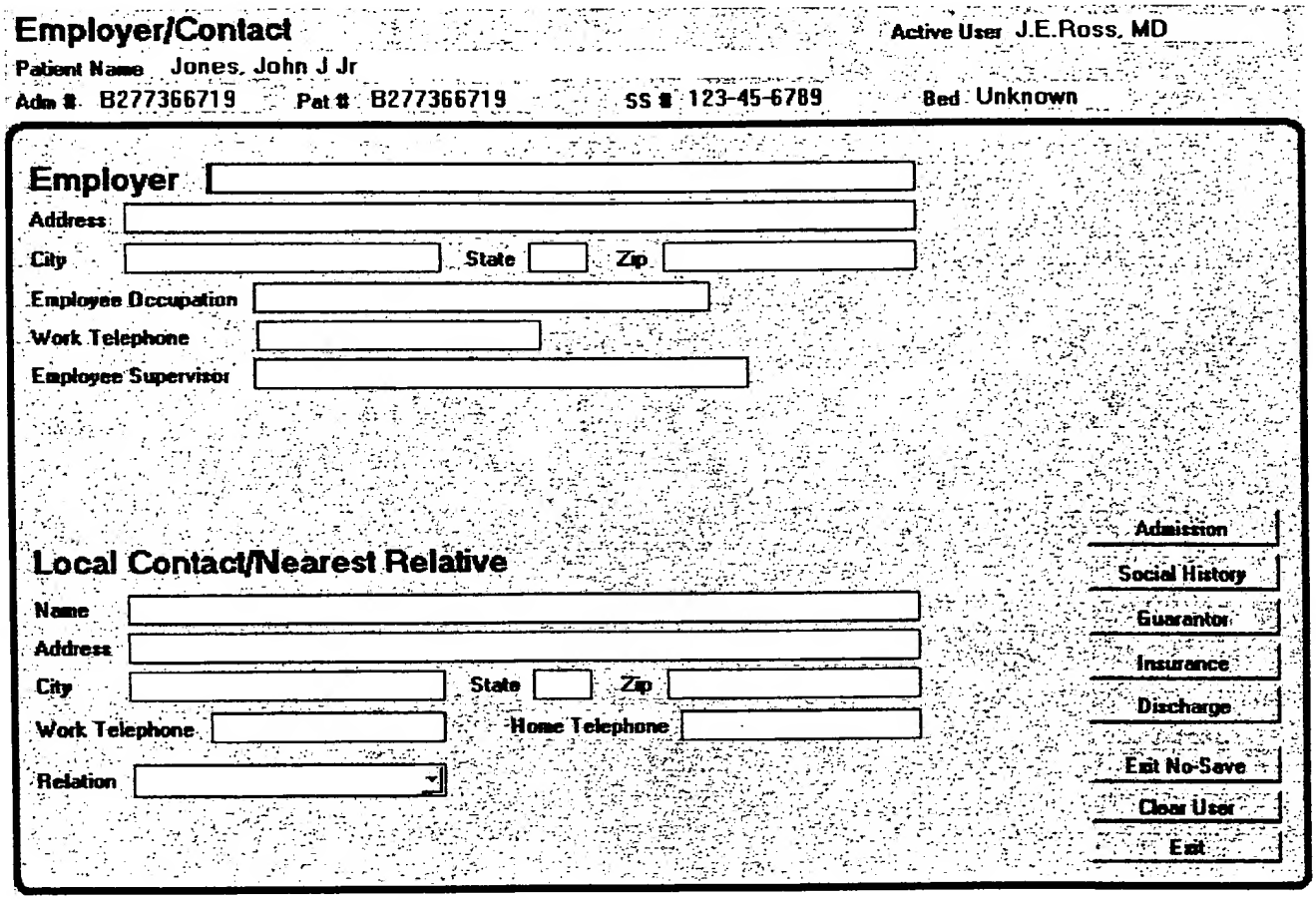


Figure Chapter 3: -24: Employer/Contact
(Image: employer-contact.bmp)

4. Click on form fields to complete as appropriate.

Exit

5. Click the Exit button to save updated patient information.

Assigning/Changing ED Physician

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Physician

3. Click on the Physician button at the right of screen.

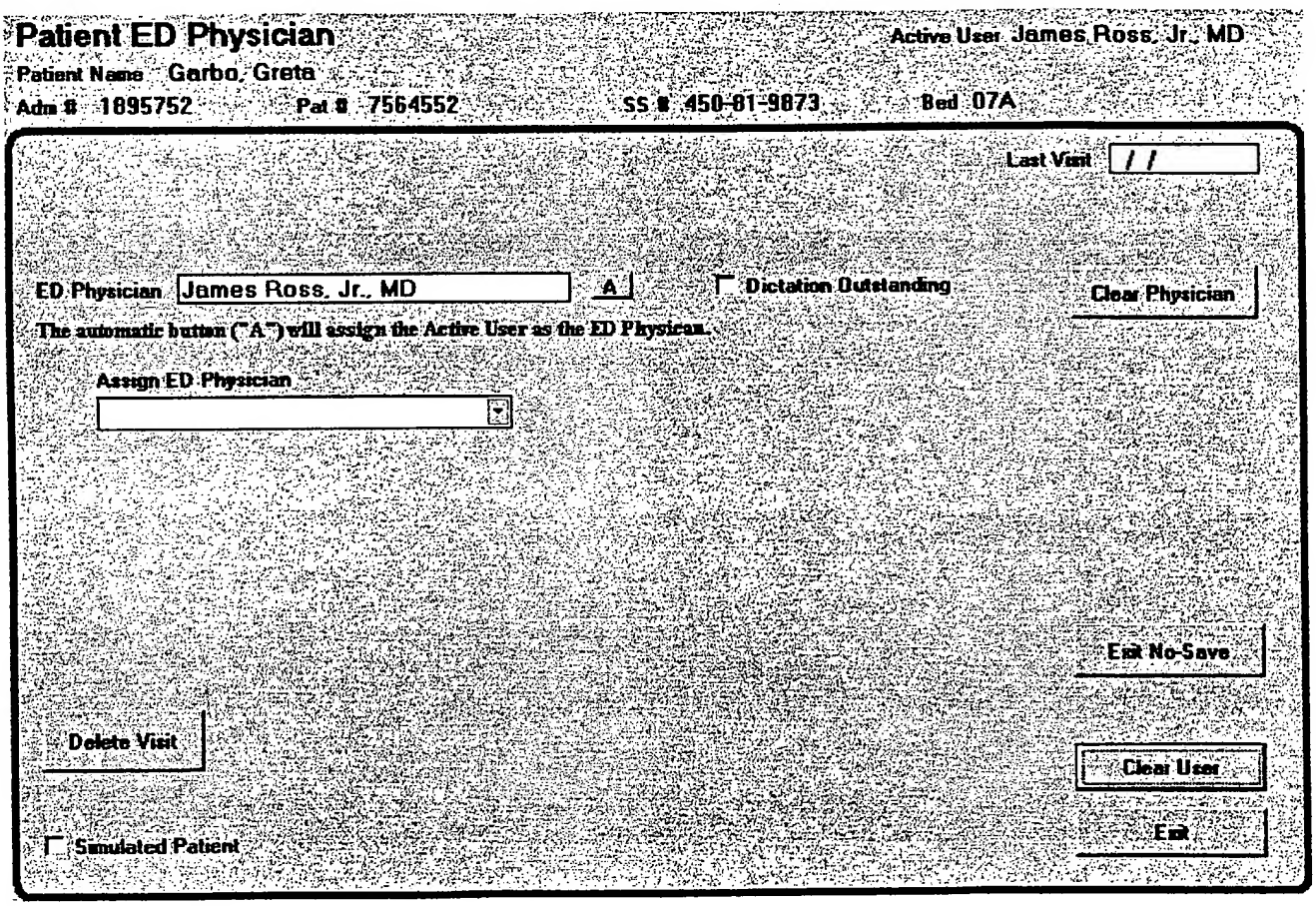


Figure Chapter 3: -25: Patient Ed Physician

(Image: patient-ed-physician.bmp)

4. Click on form fields to complete as appropriate.

Exit

5. Click the Exit button to save updated patient information.

Tips and Hints: *Patient Information:*

- There is no need to capitalize a patient's first letters or initials. TeleMed will capitalize these letters automatically.
- Any of the following screens provides access to each other:

  Admission
  Discharge
  Employer/Contact
  Guarantor
  Insurance
  Social History

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Discharging, Admitting or Transferring Patients from the ED

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Discharge

3. Click on the Discharge button at the right of screen.

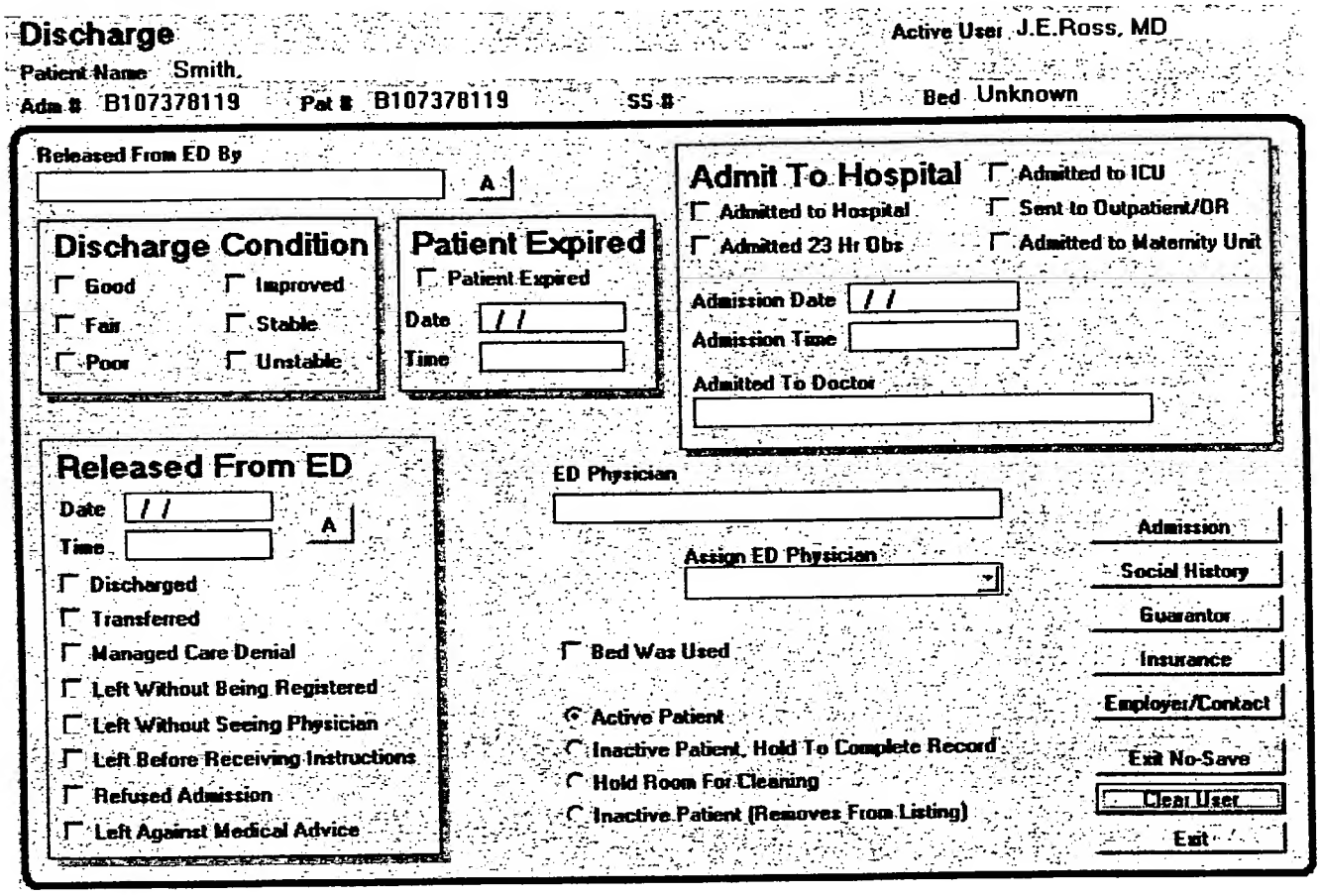

Figure Chapter 3: -26: Discharge

(Image: discharge.bmp)

4. Click on check boxes and form fields to complete as appropriate.

   NOTE: The A button will automatically insert the actual date and time in the "Released From ED" or your name in "Release From ED By" sections.

Exit

5. Click the Exit button to save updated patient information.

TeleMed Triage (Nurses)

Entering/Modifying Triage Information

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

Click on the Triage button in the INPUT section.

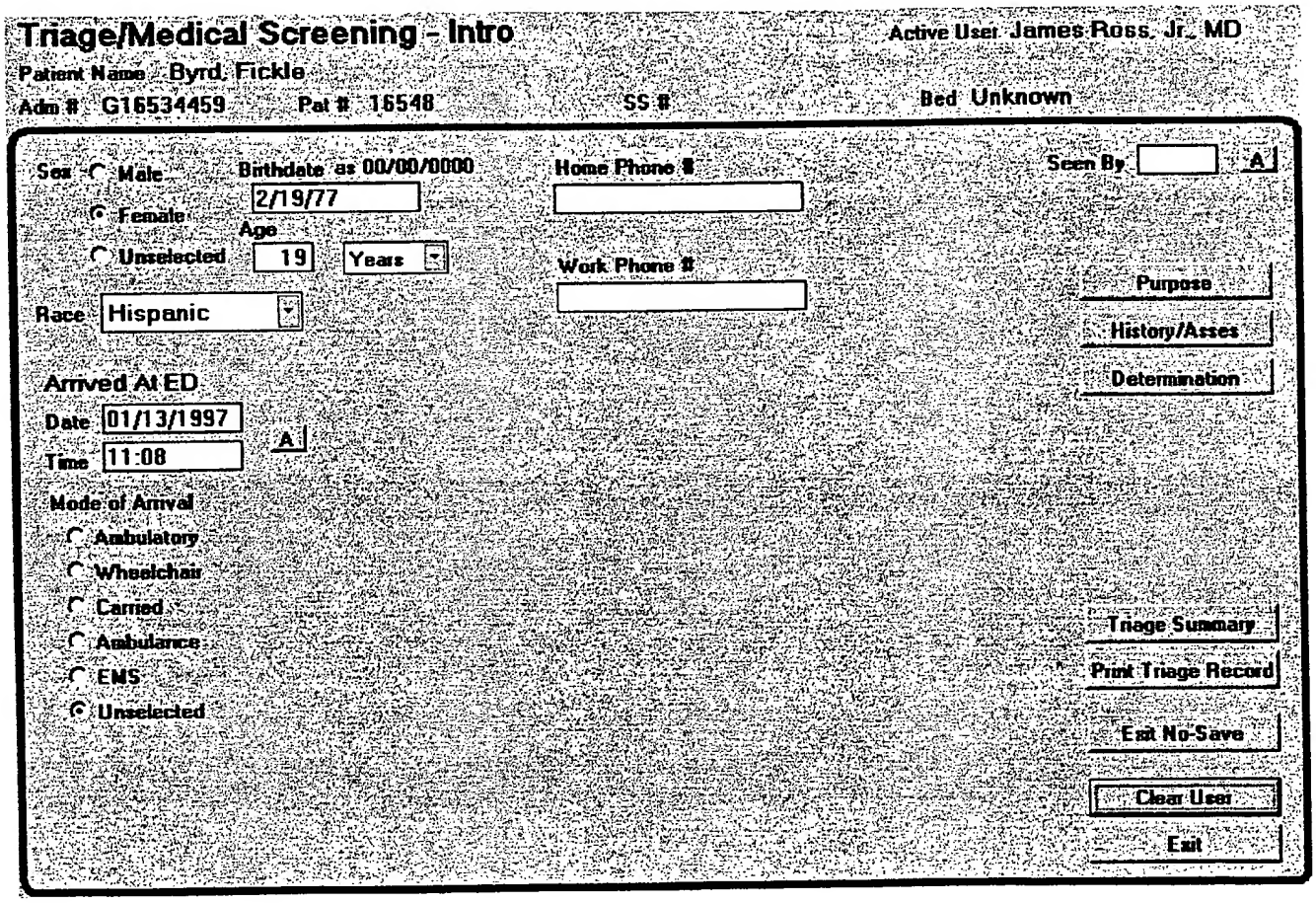

Figure Chapter 3: -27: Triage/Medical Screening - Intro

(Image: triagemed-screen-intro.bmp)

4. Click on check boxes and form fields to complete as appropriate.

Entering/Modifying Triage Information *(continued)*

Purpose

5. Click the Purpose button to continue entering patient information.

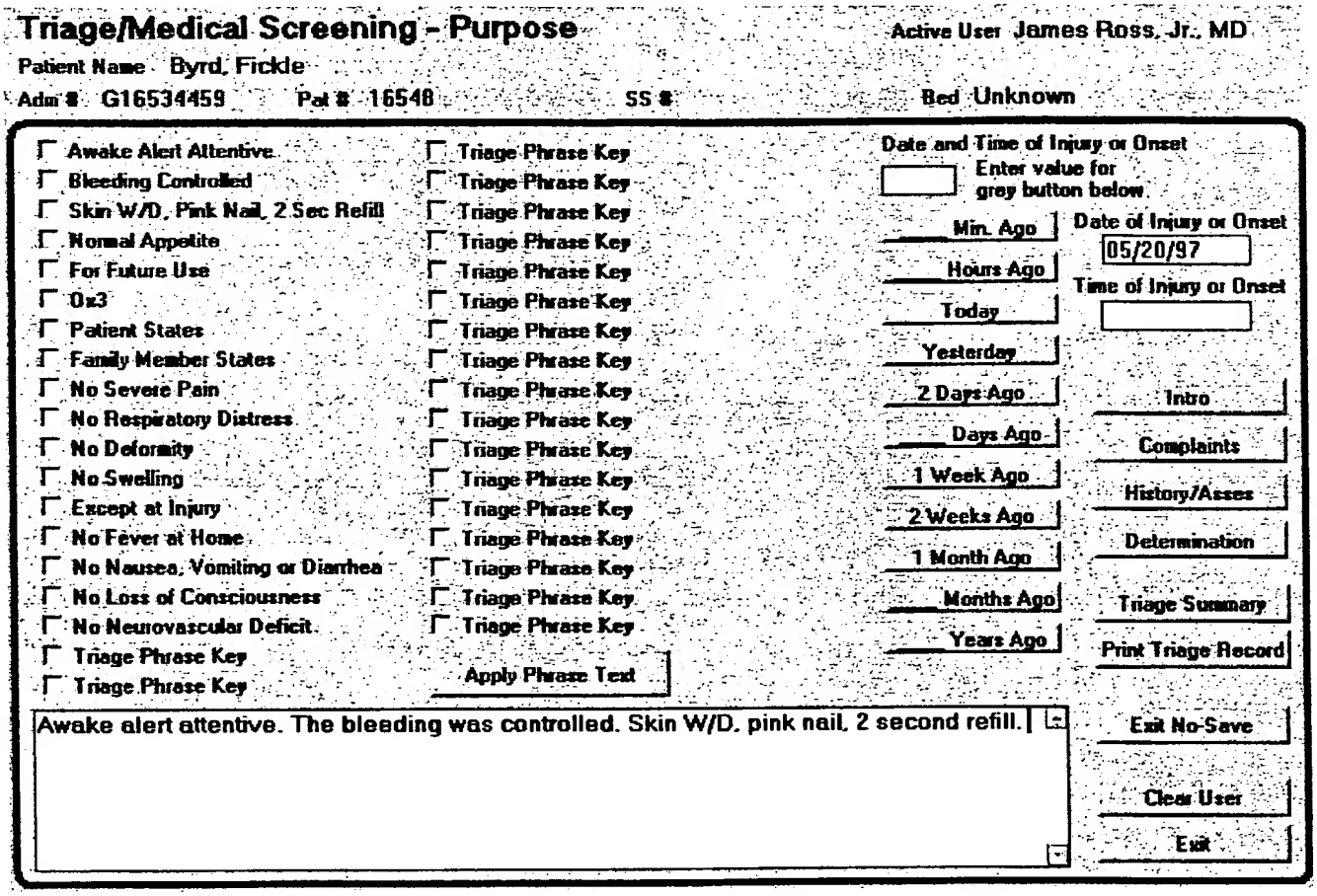

Figure Chapter 3: -28: Triage/Medical Screening - Purpose

(Image: triage-med-screen-purpose.bmp)

6. Click on check boxes and form fields to complete as appropriate.

Entering/Modifying Triage Information *(continued)*

History/Asses

7. Click the History/Asses. button to continue entering patient information.

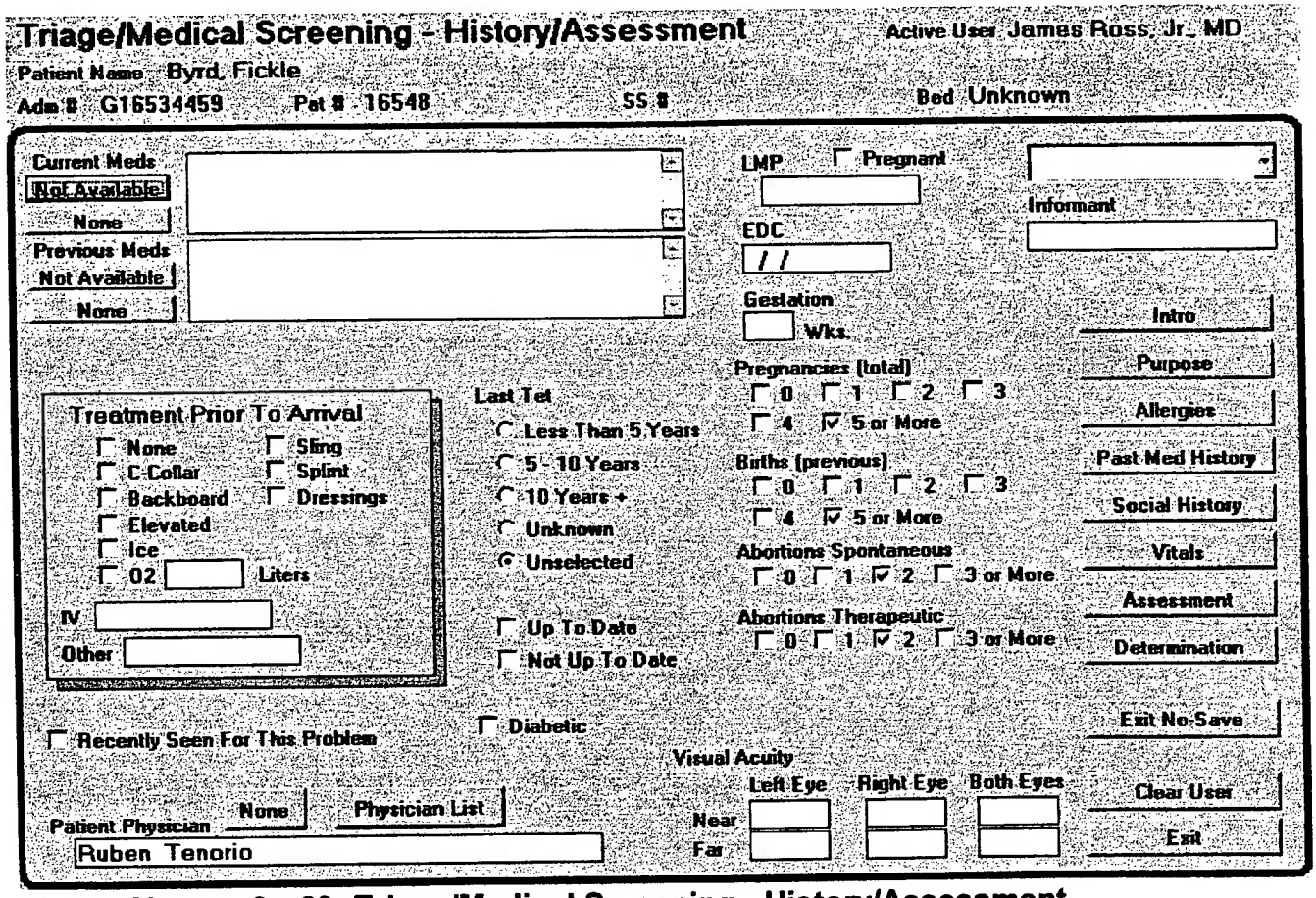

Figure Chapter 3: -29: Triage/Medical Screening - History/Assessment

(Image: triage-med-screen-history-assess.bmp)

8. Click on check boxes and form fields to complete as appropriate.

Entering/Modifying Triage Information *(continued)*

Determination

9. Click the History/Asses. button to continue entering patient information.

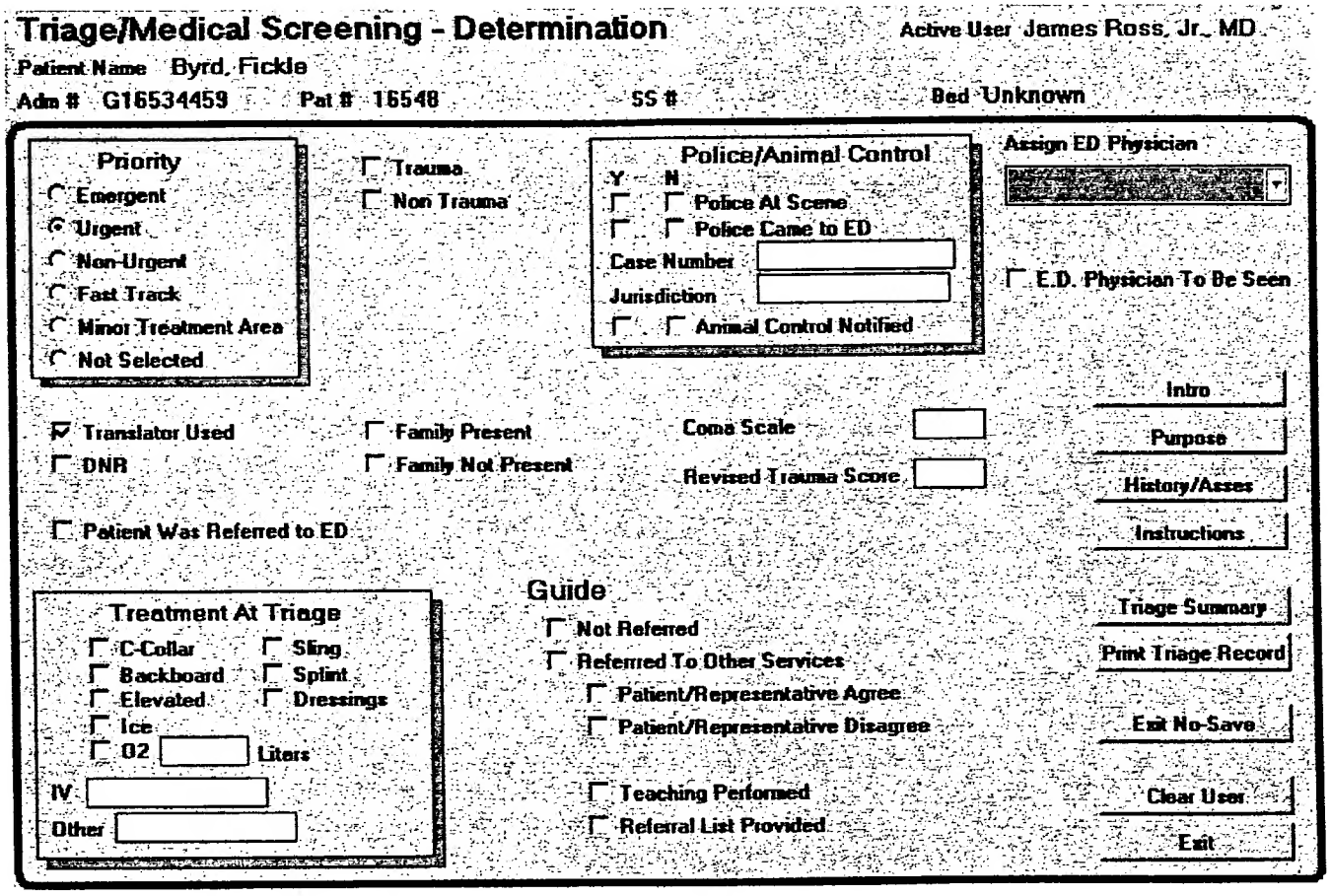

Figure Chapter 3: -30: Triage/Medical Screening - Determination

(Image: triage-med-screen-determination.bmp)

Exit

8. Click on check boxes and form fields to complete as appropriate.
9. Click the Exit button to save updated patient information.

Printing and Viewing Triage Summary

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Triage button in the INPUT section.
[brings you to Triage (screen) 1]

4a. Click on Triage Summary button to view.

or

4b. Click on Print Triage Record button to print.

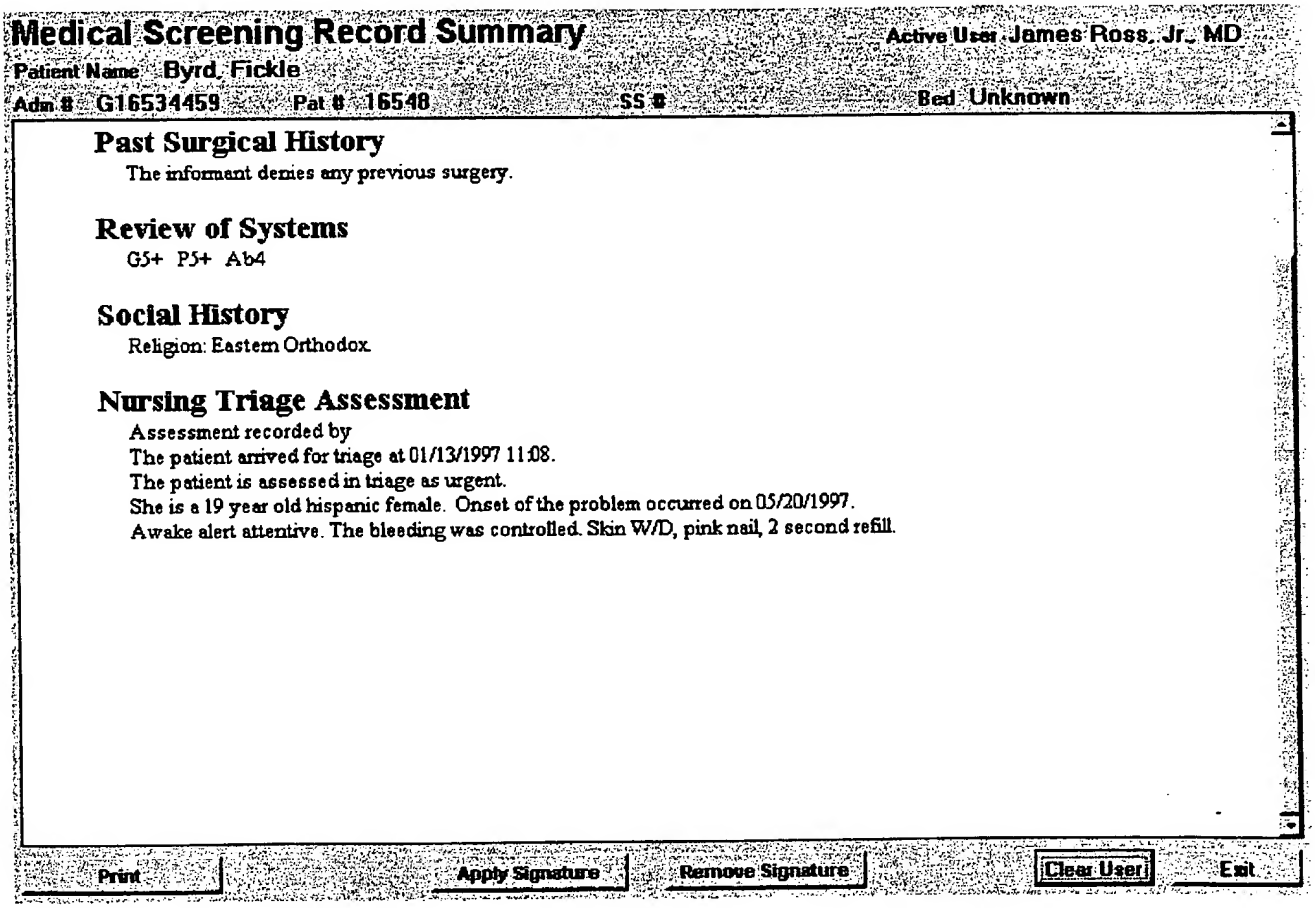

Figure Chapter 3: -31: Triage Summary

(Image: triage-summary.bmp)

Tips and Hints: *Triage:*

In **History/Assessment,** ...

- if the patient is a female of childbearing age, you need to enter the **Last Menstrual Period** in the LMP field (Example: 10/20/96 or 10/20/1996).
- click once on the box (Pregnant), in center of screen, if the patient is pregnant. TeleMed will automatically calculate the EDC and weeks of gestation. You should also enter the patient's history below for Gravida, Para, and Abortions.
- Please note if a *patient is* entered as a male you will not be able to enter an LMP.
- you can type in the physician's name or look it up in your phone directory by clicking once on **Physician List.** By typing the first 2 to 3 letters of the physician's name, the list will scroll down to the names with the same first letters. Highlight the correct physician by clicking on it once.

In **Intro,** ...

- Clicking on the "A" button will change the time and date to the current time and date. The patient's time of arrival defaults to the time the patient was entered (New Visit) in the computer.

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TeleMed Basic Patient Clinical Information (Doctors and Nurses)

Chief Complaints

Entering/Modifying Chief Complaint and Additional Complaints (std. menus)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).
2. Click the Medical Information button.
3. Click on the Complaint button in the INPUT section.
   [brings you to the Complaint-Non-Pain screen]

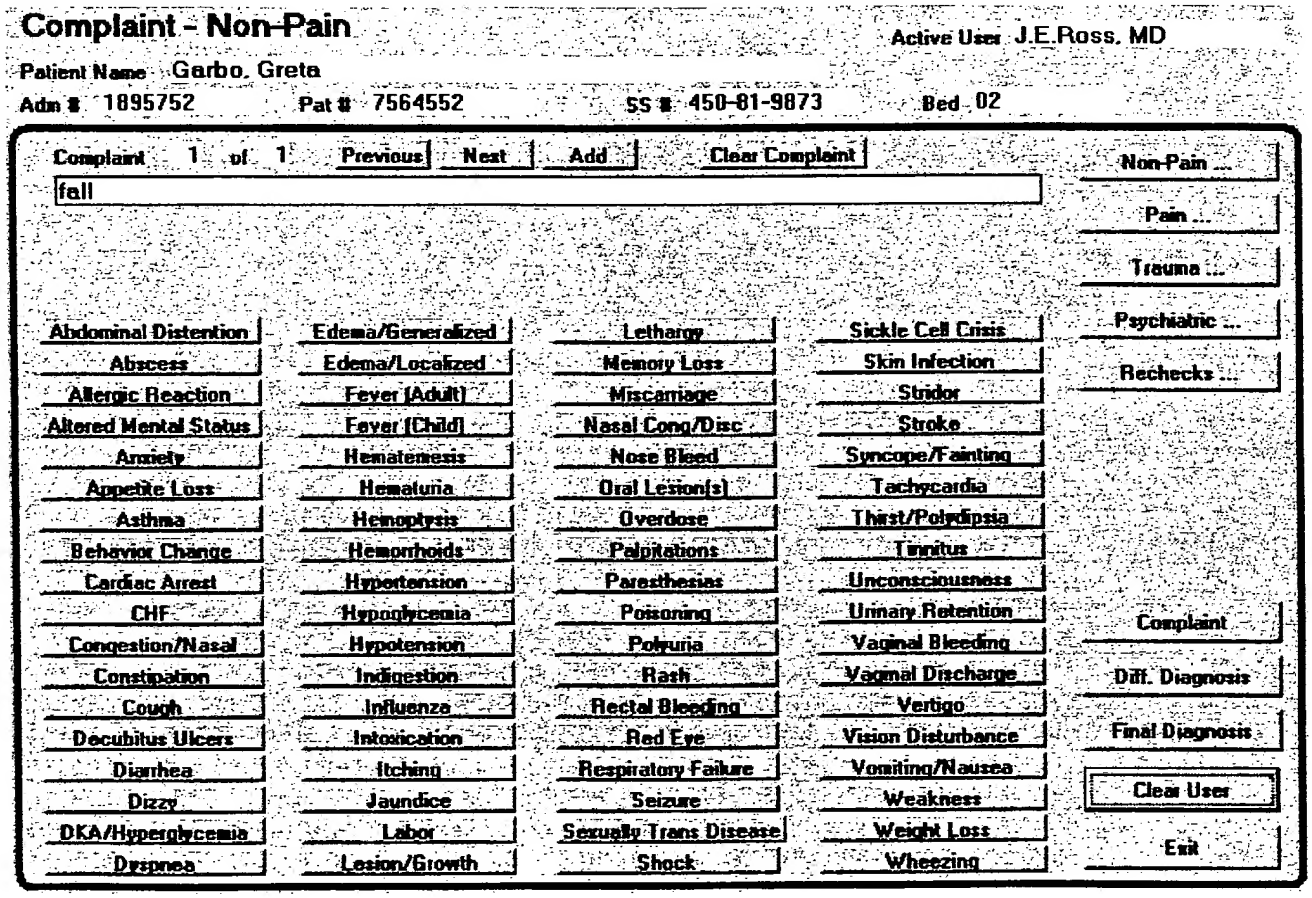
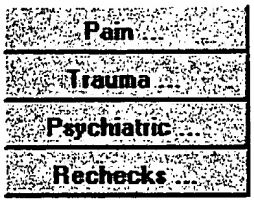


Figure Chapter 3: -32: Complaint - Non-Pain
(Image: complaint-non-pain.bmp)

Alternate access to this screen:

- Differential Diagnosis and Final Diagnosis

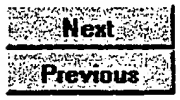
Entering/Modifying Chief Complaint and Additional Complaints (std. menus) *(cont.)*



4. Go to (click) the appropriate Complaint category (if other than Non-Pain); IE. Pain, Trauma, Psychiatric or Rechecks.
5. Select complaints by clicking on the appropriate complaint buttons.

6. Use the Add button to enter any additional complaints (note the "Complaint 1 of 1" top left of screen maintains a count of complaints).

Note: A complaint can be manually entered (in form field) if it is not currently listed on any of the TeleMed complaint screens' buttons.



Note: Use the Next and Previous buttons to review currently entered Complaints.

Note: If you wish to remove a complaint you have entered, use the Clear Complaint button.

7. Click the Exit button to save updated patient information.

Entering/Modifying Chief Complaint and Additional Complaints (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Transcript Editor button in the HISTORICAL section.

4a. Entering a new Chief Complaint entry:

- Click on To Add button.
- Open the pull down menu and select "Chief Complaint".

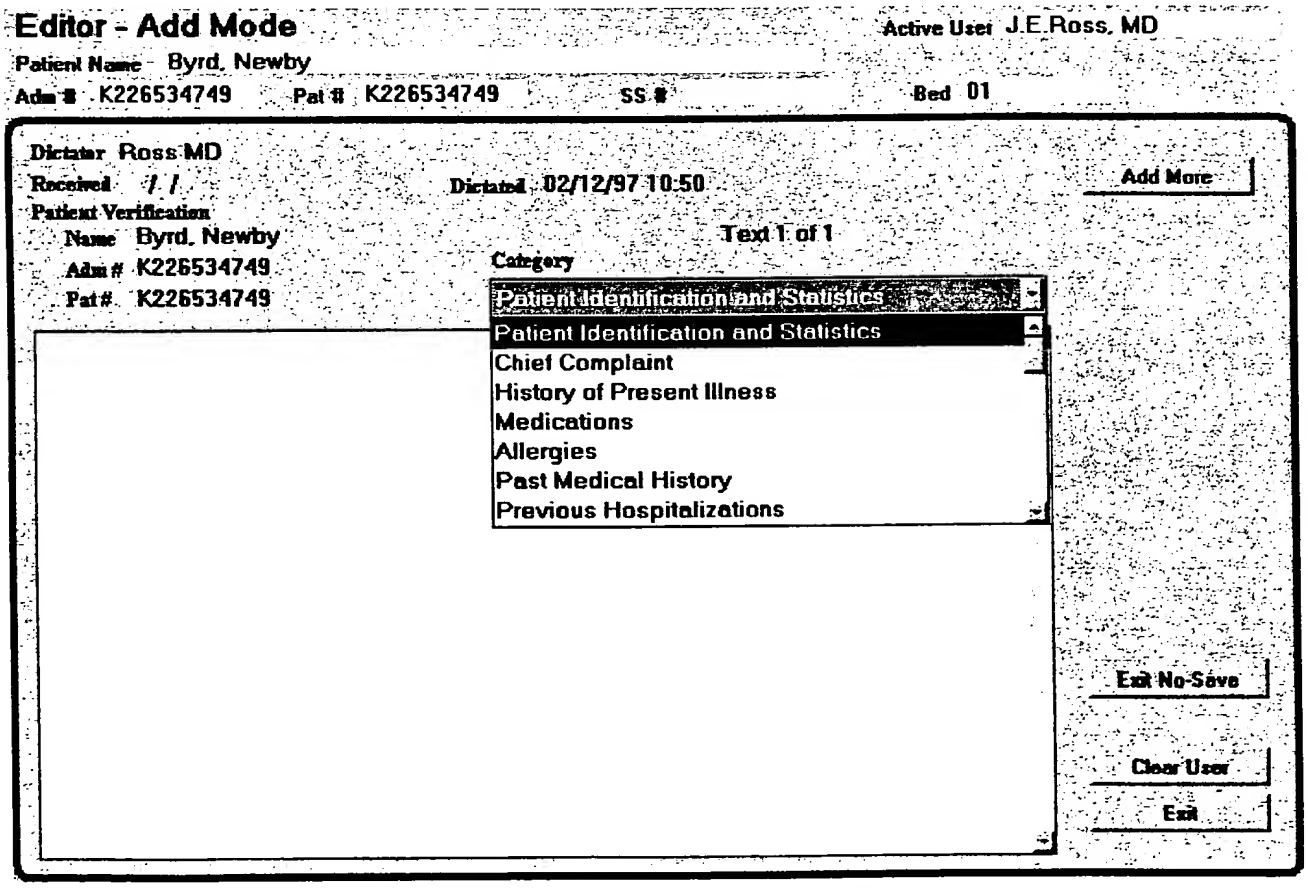
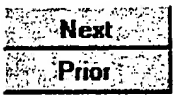


Figure Chapter 3: -33: Chief Complaint (in Editor Add Mode)

(Image: editor-add-mode-1.bmp)

Entering/Modifying Chief Complaint and Additional Complaints (manual) *(continued)*



4b. Modify an existing Chief Complaint entry:

- Click on Next / Prior (or First / Last) buttons to locate Chief Complaint.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

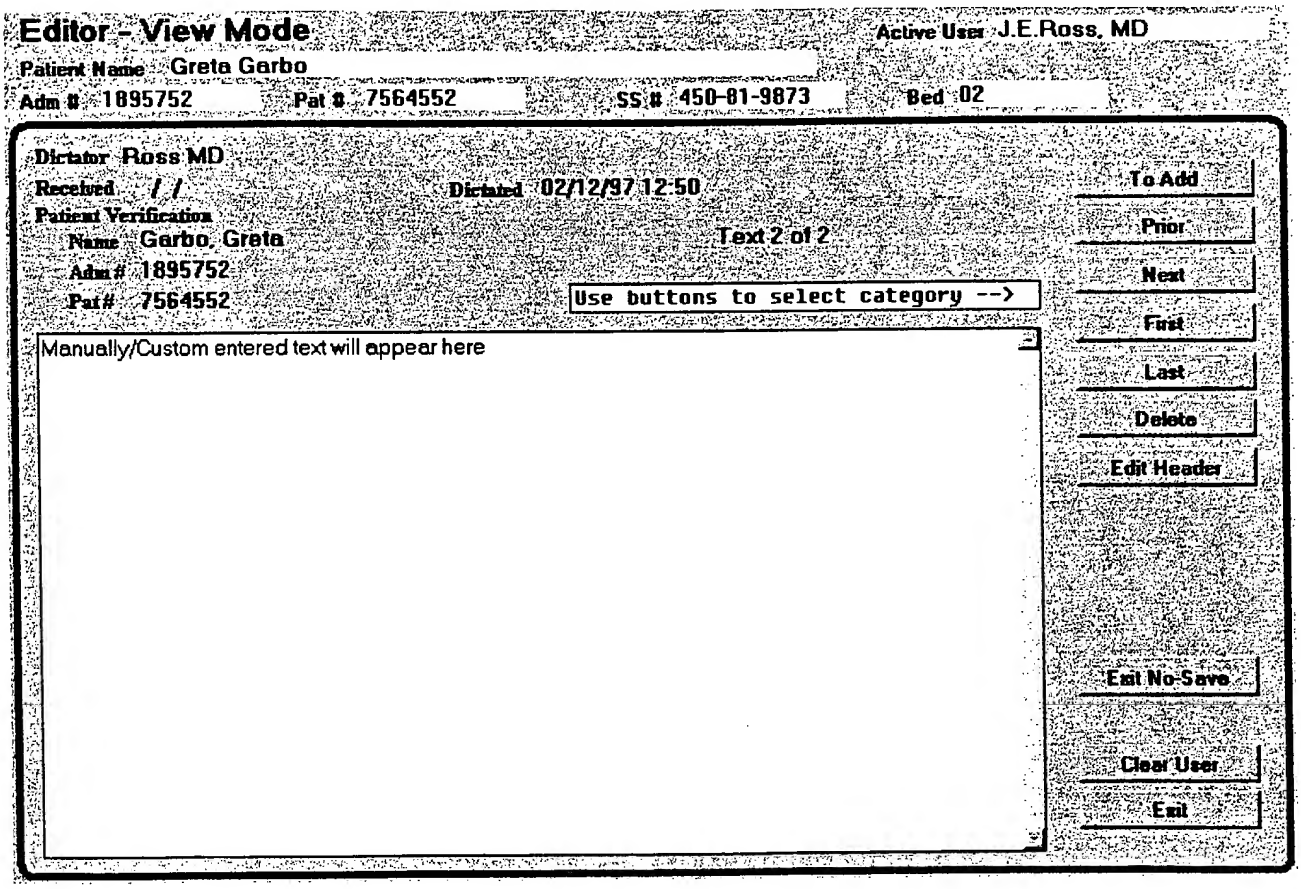


Figure Chapter 3: -34: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

6. Click the Exit button to save updated patient information.

Viewing Current Chief Complaint(s)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Summary button in the HISTORICAL section. [brings you to the Medical Record Summary]

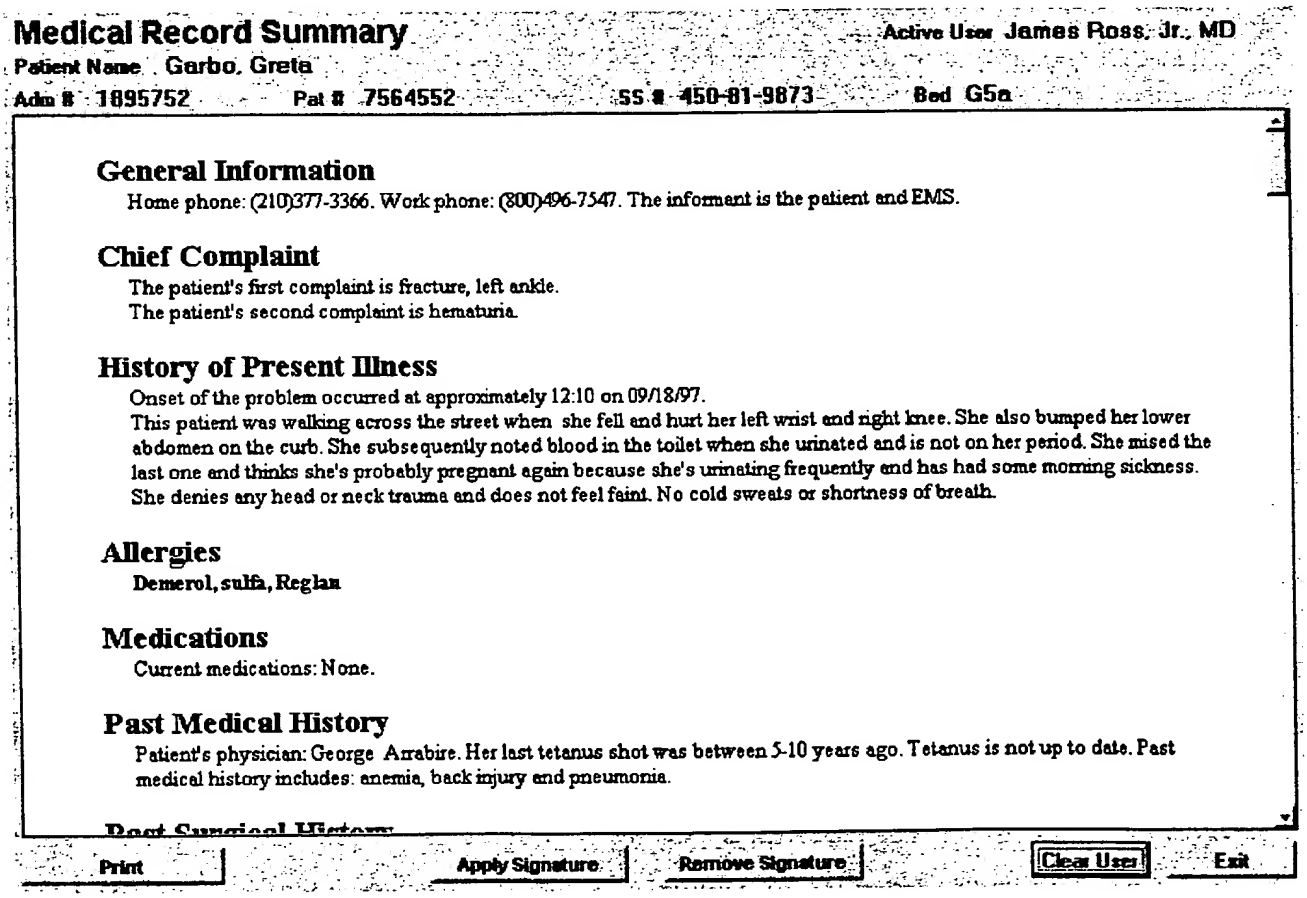
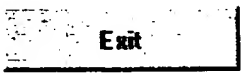


Figure Chapter 3: -35: Medical Record Summary

(Image: medical-record-summary.bmp)

4. Click the Scroll Bar to view additional information.



5. Click the Exit button to return to the Medical Information screen.

Tips and Hints: *Chief Complaint:*

- The **Prephrased Text** function (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Chief Complaints text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.
- If the complaint you are looking for is not on any of the screens, you type it in the data field. Always try to choose a complaint from the screens. You can change the wording of the complaint or add to it after choosing it by clicking in the data field once and typing in the information you want.

History of Present Illness

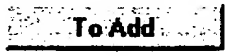
Entering/Modifying History of Present Illness (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Transcript Editor button in the HISTORICAL section.



4a) Entering a new History of Present Illness entry:

- Click on To Add button.
- Open the pull down menu and select "History of Present Illness".

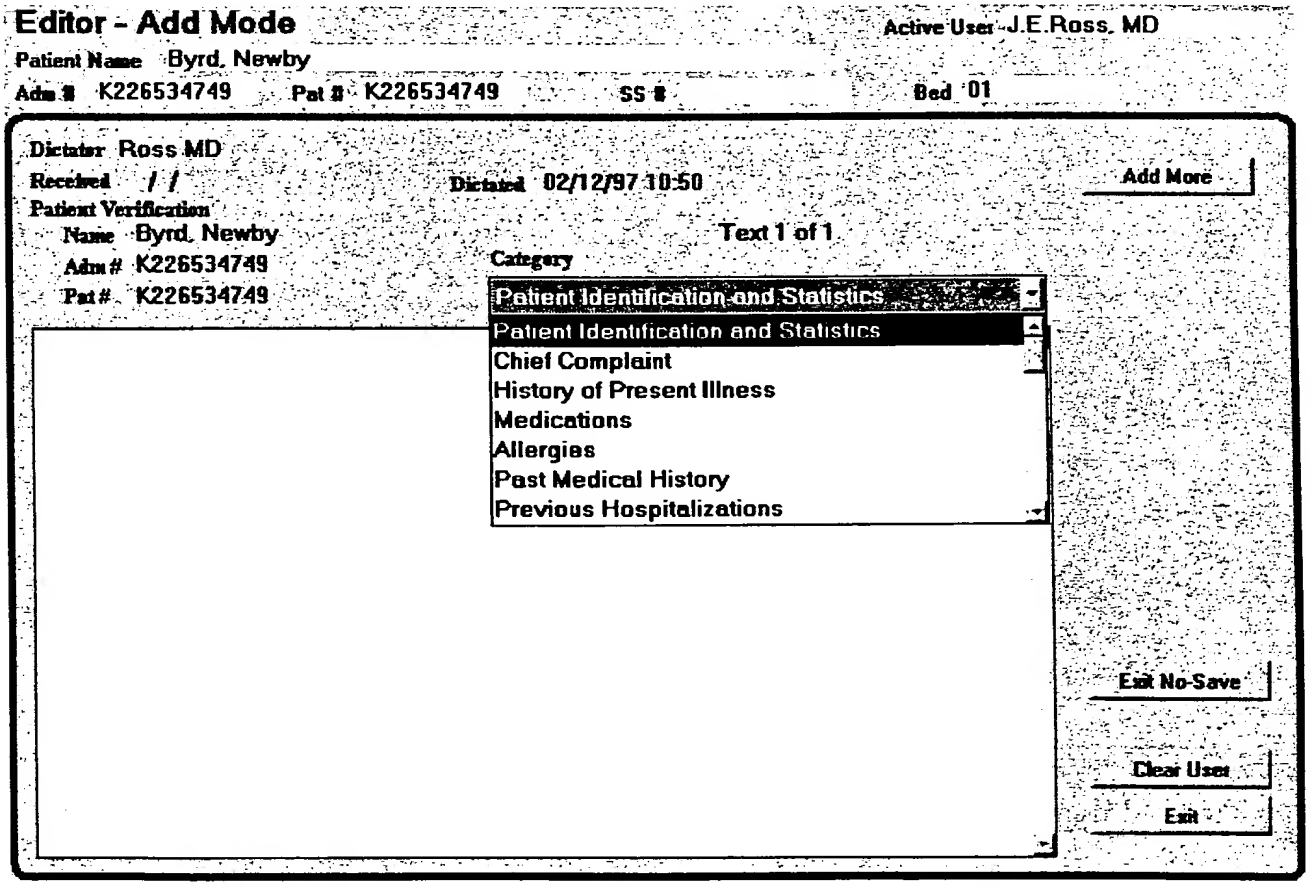


Figure Chapter 3: -36: History of Present Illness (in Editor Add Mode)

(Image: editor-add-mode-1.bmp)

Entering/Modifying History of Present Illness (manual) *(continued)*

4b. Modify an existing History of Present Illness entry:

- Click on Next / Prior (or First / Last) buttons to locate History of Present Illness.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

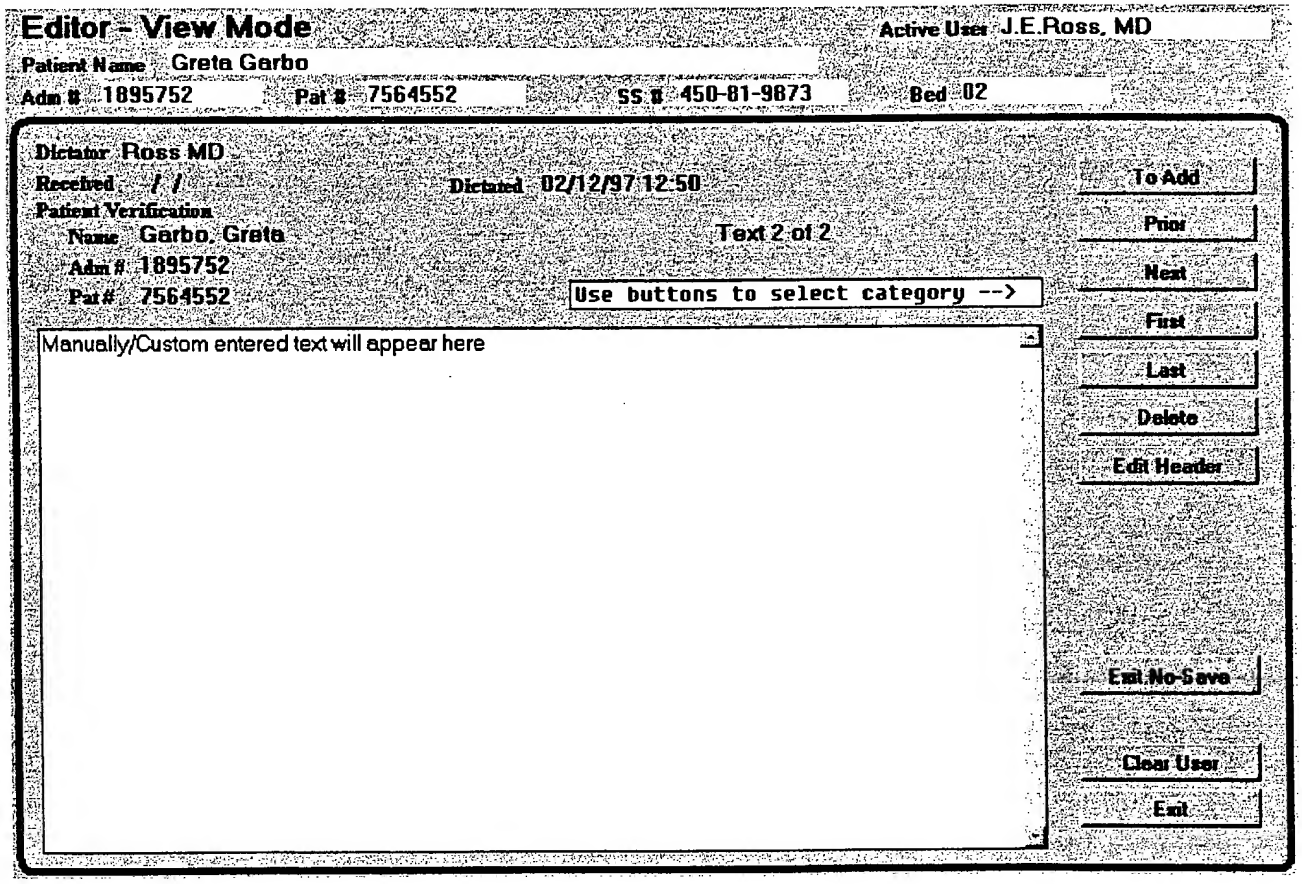
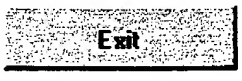


Figure Chapter 3: -37: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)



6. Click the Exit button to save updated patient information.

Viewing History of Present Illness

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Summary button in the HISTORICAL section. [brings you to the Medical Record Summary]

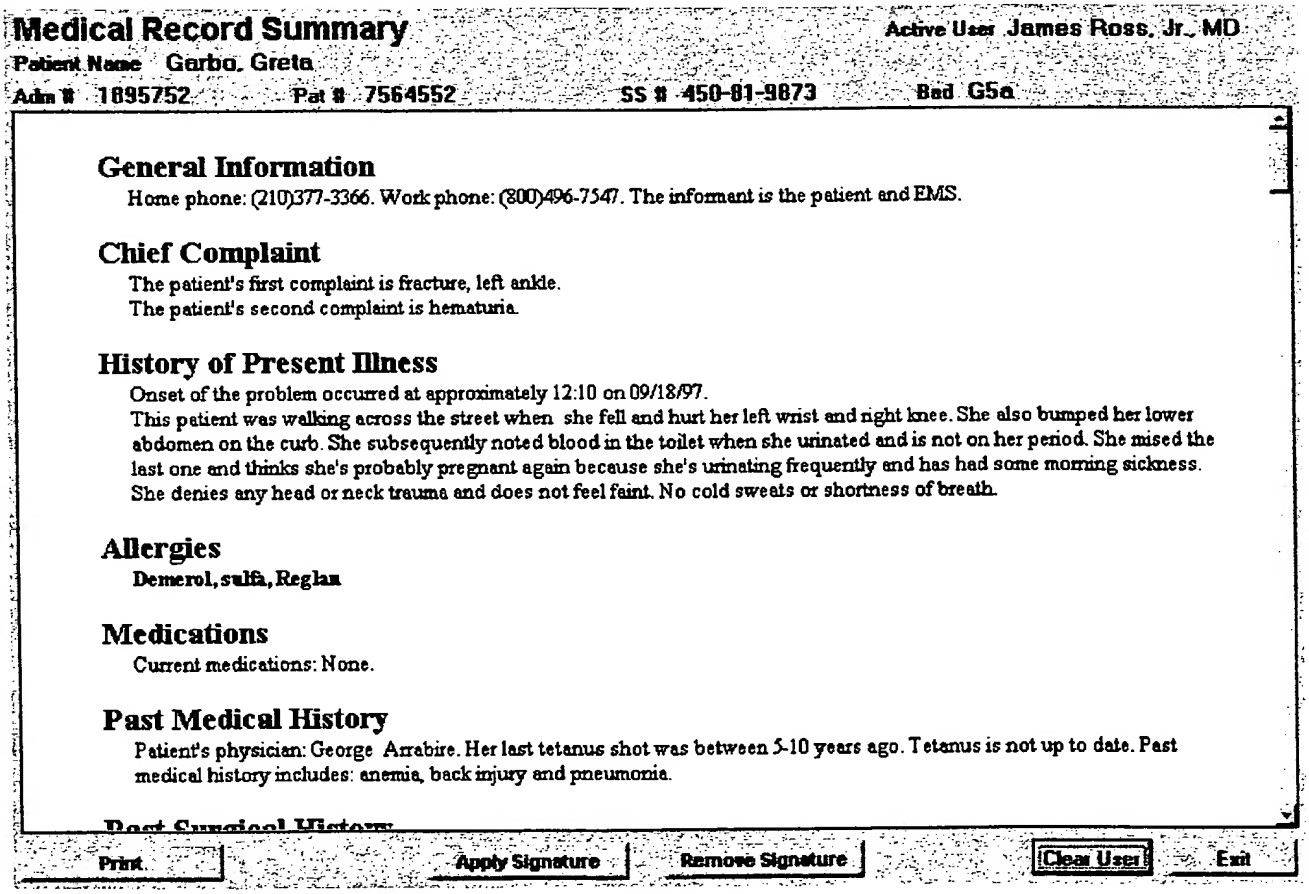


Figure Chapter 3: -38: Medical Record Summary

(Image: medical-record-summary.bmp)

4. Click the Scroll Bar to view additional information.

5. Click the Exit button to return to the Medical Information screen.

Tips and Hints: History of Present Illness:

- The **Prephrased Text** function (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based History of Present Illness text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.

Prephrased Text for the Medical Record

Entering Prephrased Text in the Medical Record (local menus)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Prephrased Text

3. Click on the Prephrased Text button in the INPUT section.

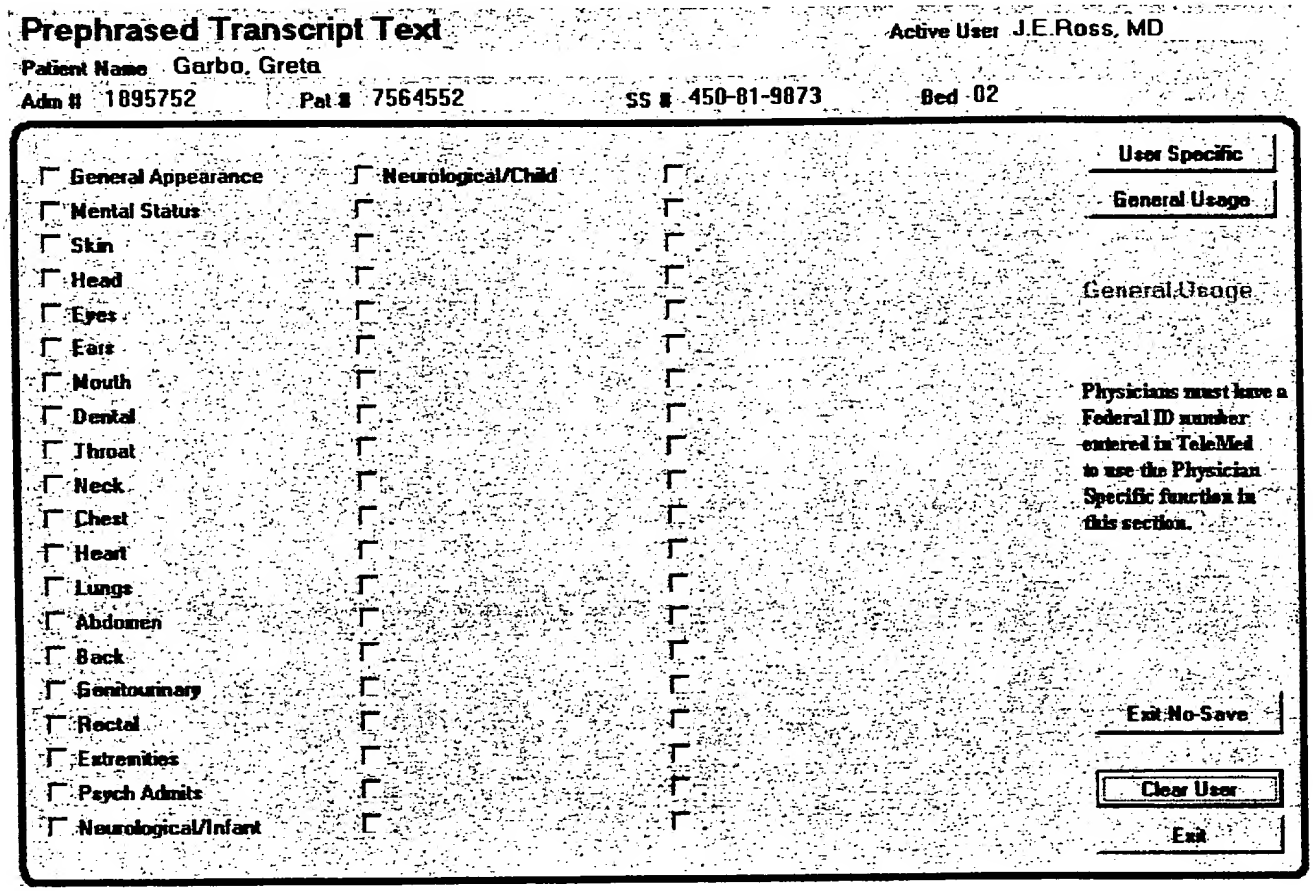


Figure Chapter 3: -39: Prephrased Transcript Text

(Image: prephrased-transcript-text.bmp)

User Specific

General Usage

4. Click the User Specific or General Usage buttons to view your user specific or ED wide Prephrased Text.
5. Select applicable Prephrased Text from the check box menu.

Exit

6. Click the Exit button to return to the Medical Information screen.

Modifying/Deleting Prephrased text in the Medical Record

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Transcript Editor button in the HISTORICAL section.

4. Click on Next / Prior (or First / Last) buttons to locate Medical Record category where Prephrased Text is placed.
5. Click on the multiline form field to manually add, delete or modify any text.

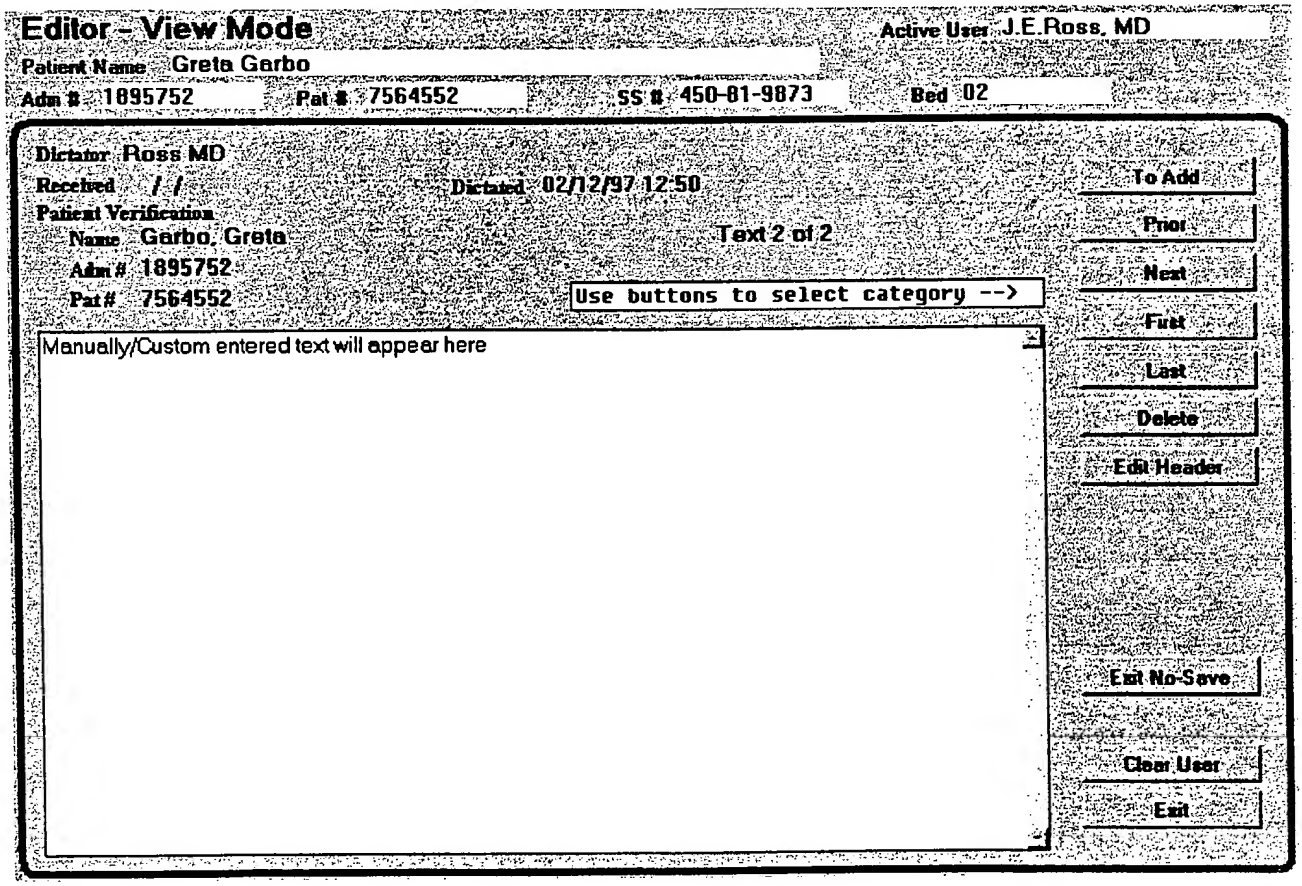


Figure Chapter 3: -40: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

6. Click the Exit button to save updated patient information.

Tips and Hints: *Prephrased Text:*

- The **Prephrased Text** function (accessed from the Medical Information screen) provides check box menus (User Specific and General Usage) for entering a variety of locally customizable Medical Record categories:

  - Patient Identification and Statistics
  - Chief Complaint
  - History of Present Illness
  - Medications
  - Allergies
  - Past Medical History
  - Pervious Hospitalizations
  - Past Surgical History
  - Review of Systems
  - Social History
  - Family History
  - Physical Exam
  - Labs
  - Tests
  - X-Rays
  - Therapeutics & Procedures
  - ED Course
  - Chart Review
  - Differential Diagnosis
  - Results of Therapy and Complications
  - Interval Exams
  - Consultations
  - Diagnosis
  - Referrals
  - Counseling
  - Prescriptions
  - Work/School Limitations/Excuse
  - Discharge
  - Neuro Assessment
  - Nurse Assessment
  - Nurse Notes
  - General

- TeleMed will automatically place your Prephrased Text entries under the appropriate Medical Record category (as you or your department defined when the entry was programmed into TeleMed).

- Use the Medical Record Summary to review / verify your modifications.
  "Grease Board" → Medical Information (button) → Summary (button)

- Creating and modifying Prephrased Text entries (User Specific and General Usage) requires System Manager privileges. See System Manager's Guide for instructions.

Past Medical/Surgical History

Entering/Modifying Past Medical/Surgical History (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Past Medical History

3. Click on the Past Medical History button in the INPUT section.
4. Click on check boxes and form fields to complete as appropriate.

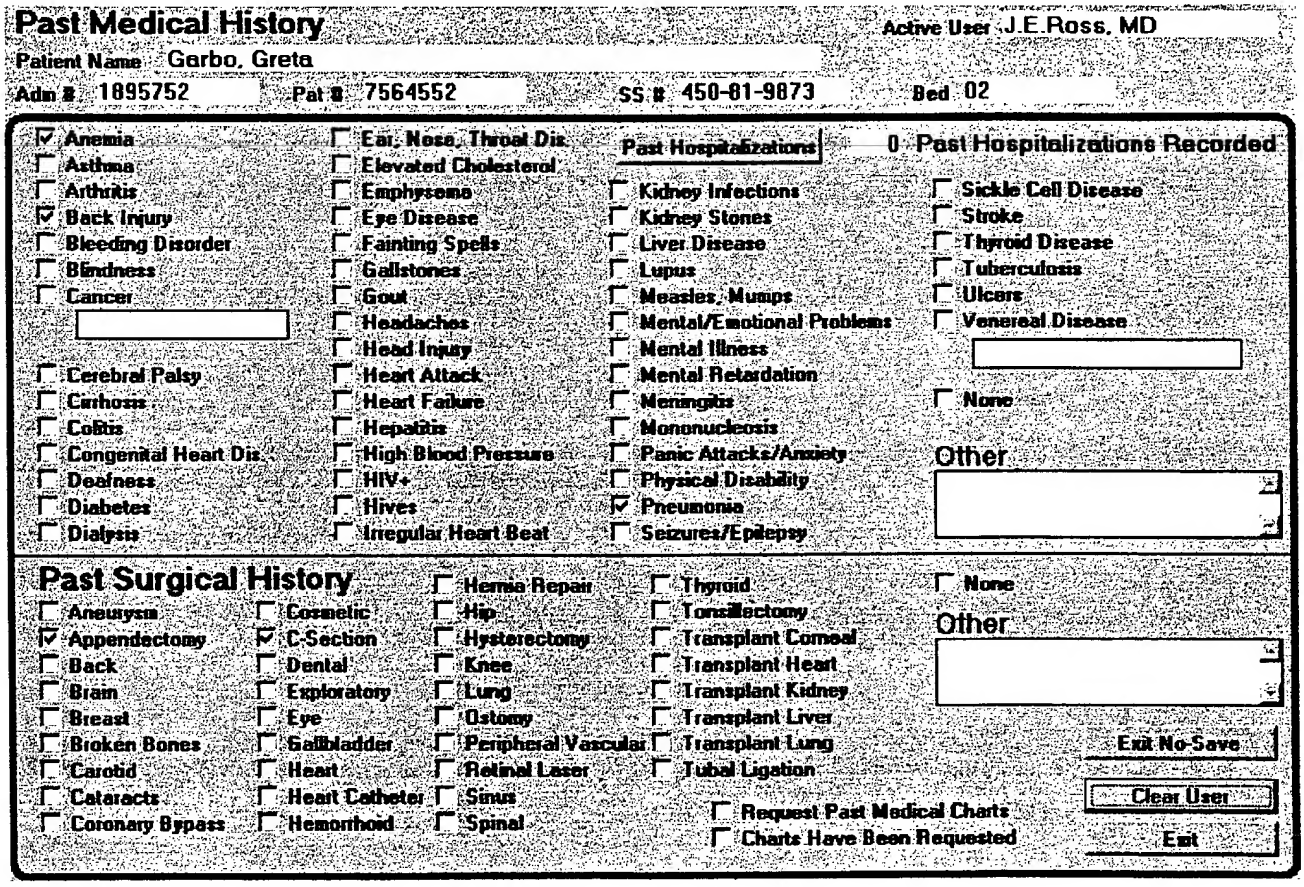


Figure Chapter 3: -41: Past Medical/Surgical History

(Image: past-med-history.bmp)

Exit

6. Click the Exit button to save updated patient information.

Entering/Modifying Past Medical/Surgical History (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Transcript Editor button in the HISTORICAL section.

4a) Entering a new Past Medical/Surgical History entry:

- Click on To Add button.
- Open the pull down menu and select "Past Medical History".

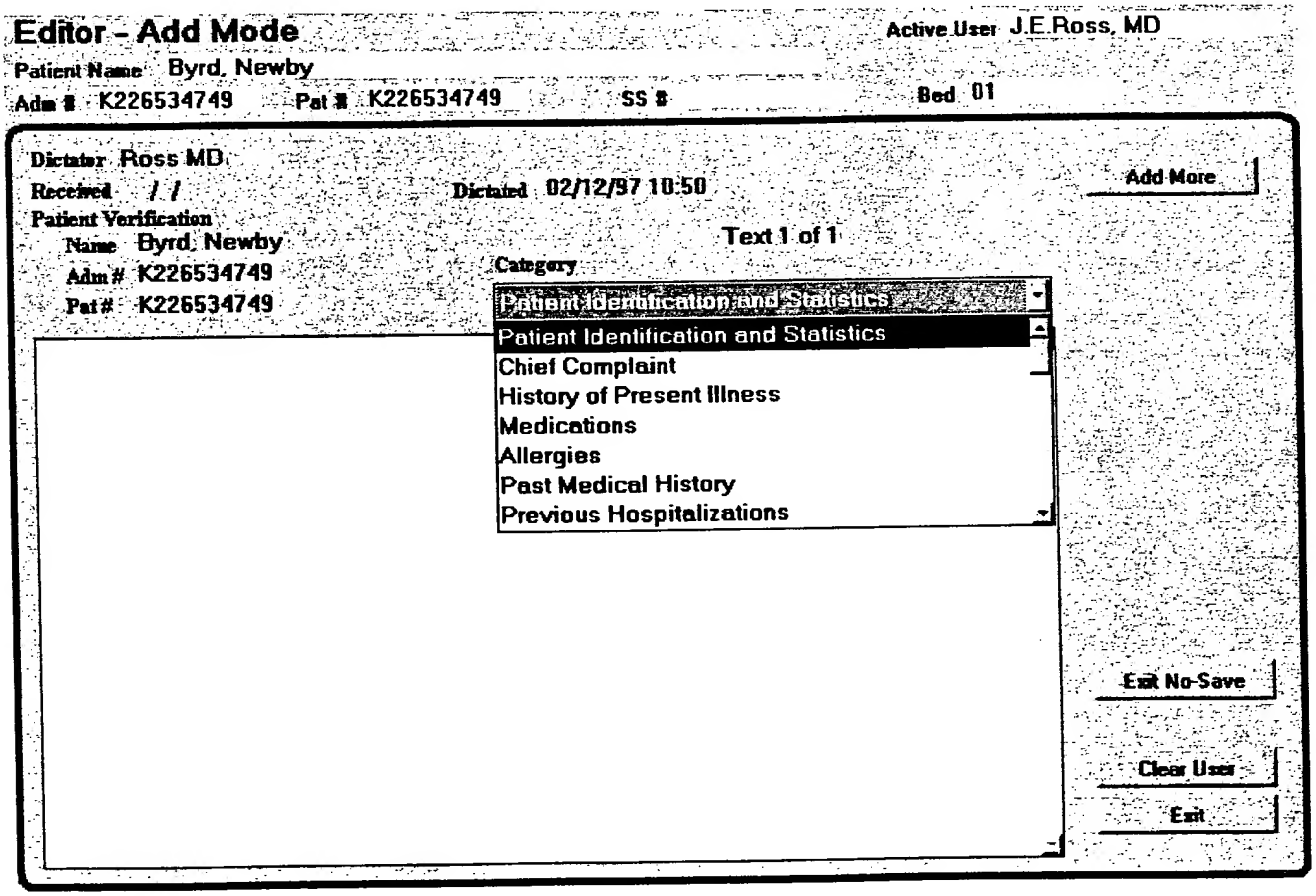


Figure Chapter 3: -42: Past Medical History (in Editor Add Mode)

(Image: editor-add-mode-1.bmp)

Entering/Modifying Past Medical/Surgical History (manual) *(continued)*

4b. Modify an existing Past Medical/Surgical History entry:

- Click on Next / Prior (or First / Last) buttons to locate Past Medical/Surgical History.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

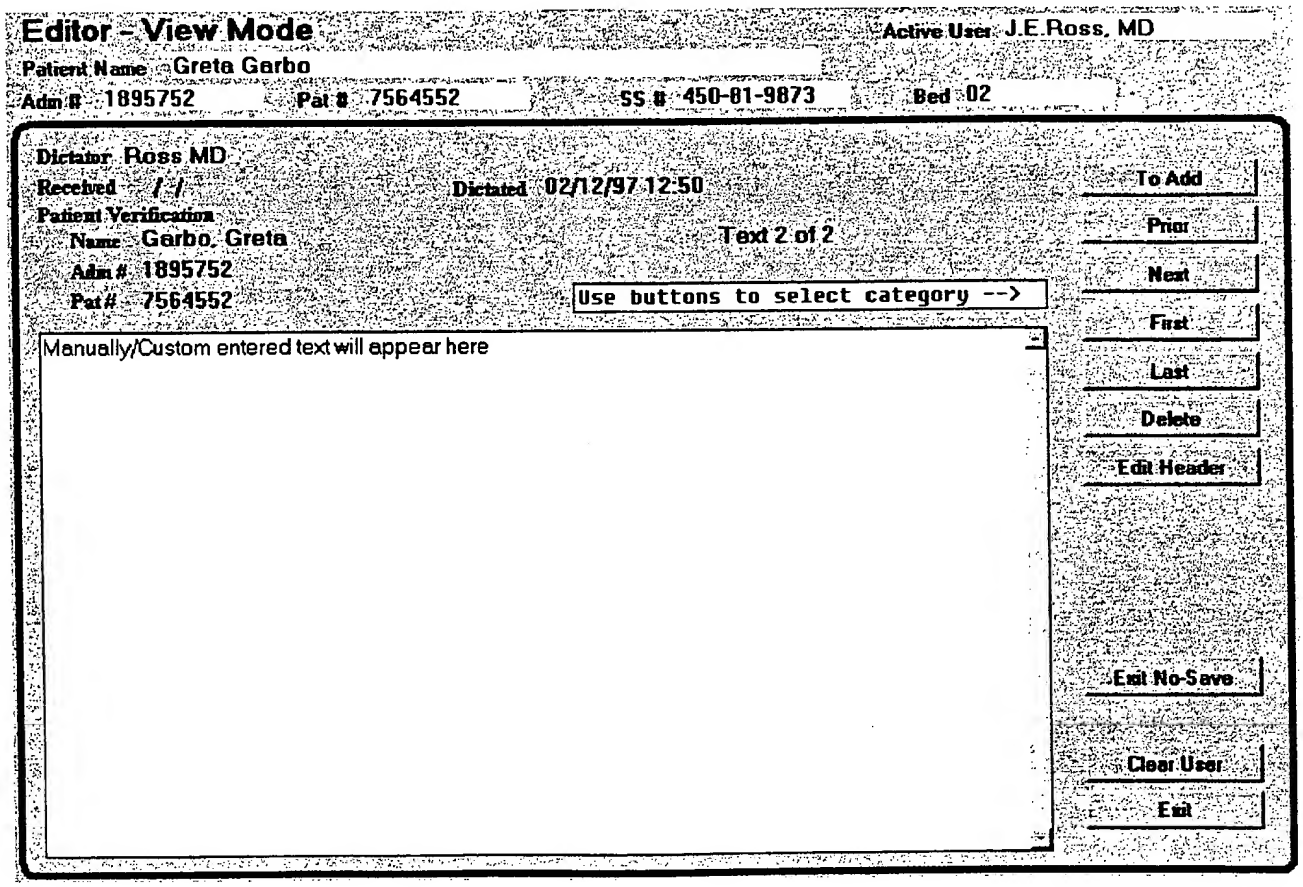


Figure Chapter 3: -43: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

6. Click the Exit button to save updated patient information.

Viewing Past Medical/Surgical History

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).
2. Click the Medical Information button.
3. Click on the Summary button in the HISTORICAL section. [brings you to the Medical Record Summary]

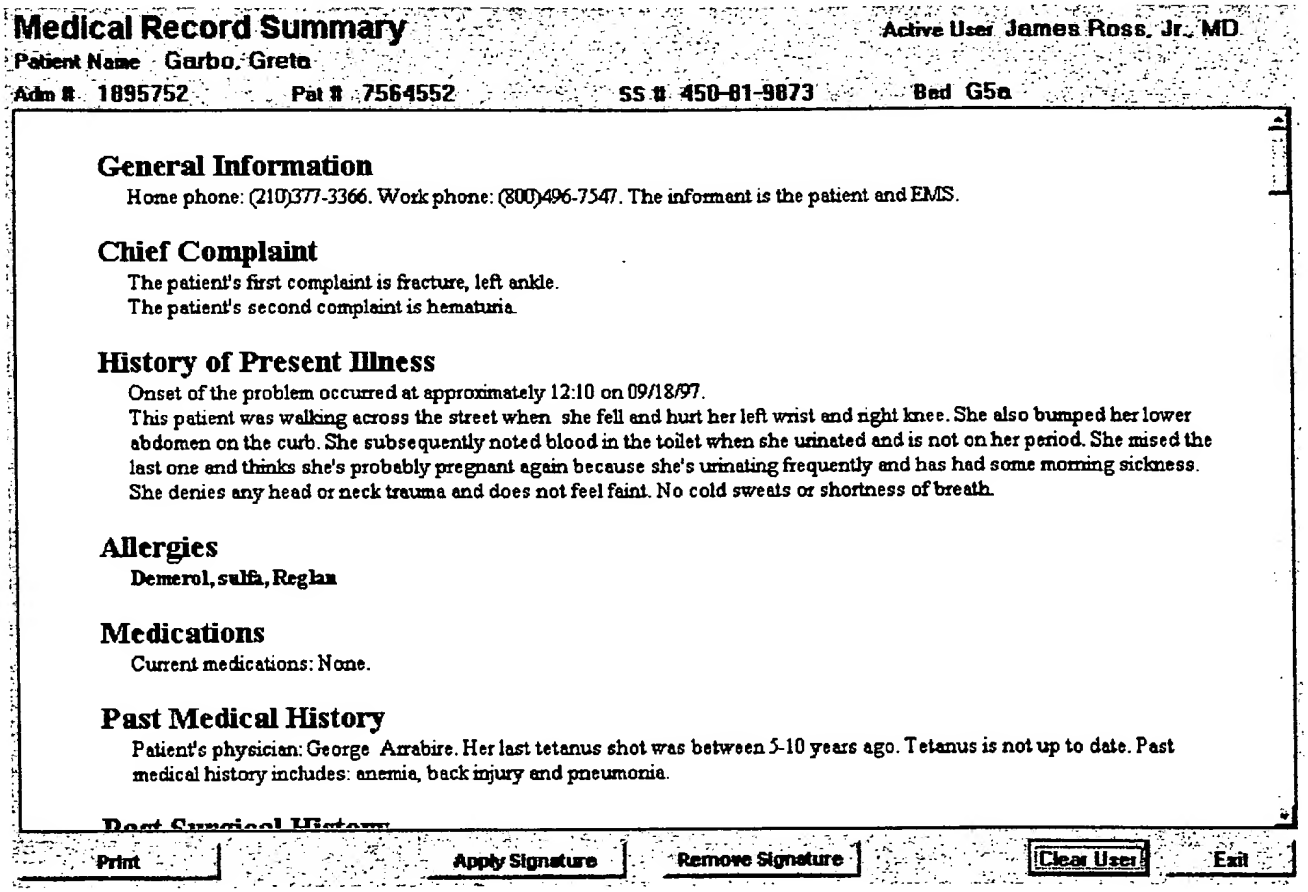


Figure Chapter 3: -44: Medical Record Summary

(Image: medical-record-summary-a.bmp)

4. Click the Scroll Bar to view additional information.
5. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Past Medical/Surgical History:

- The **Prephrased Text** function (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Past Medical/Surgical History text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.

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Past Hospital Admissions

Entering/Modifying Past Hospital Admissions (via std. menu)

*From the "Active Patient List" (your main tracking screen)**

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Past Medical History button in the INPUT section.

4. Click on the Past Hospitalizations button.
5. Complete the form fields as appropriate. (note instructions on screen)

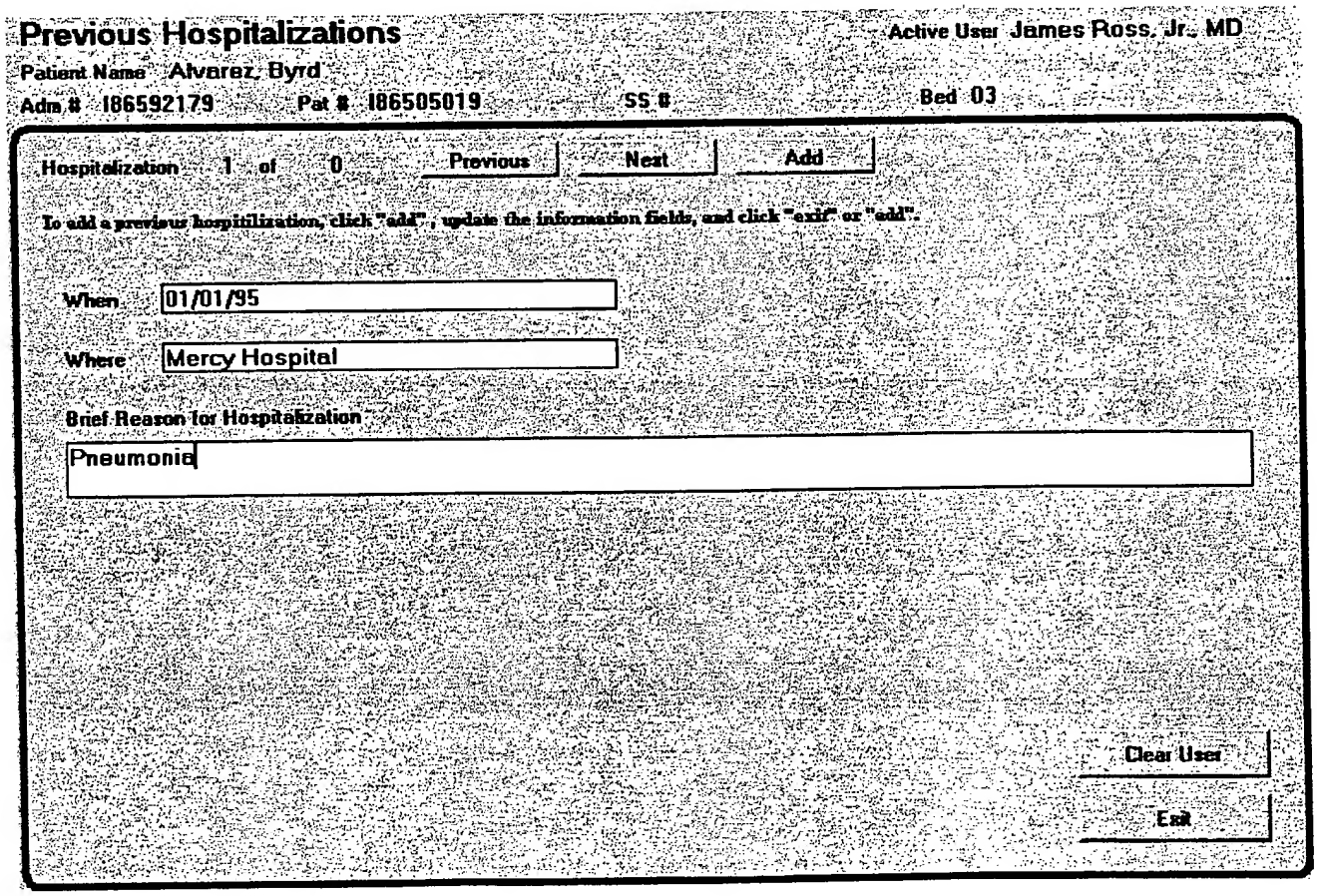


Figure Chapter 3: -45: Previous Hospitalizations

(Image: previous-hospitalizations.bmp)

6. Click the Exit button to save updated patient information.

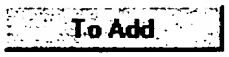
Entering/Modifying Past Hospital Admissions (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Transcript Editor button in the HISTORICAL section.



4a) Entering a new Past Hospital Admissions entry:

- Click on To Add button.
- Open the pull down menu and select "Previous Hospitalizations".

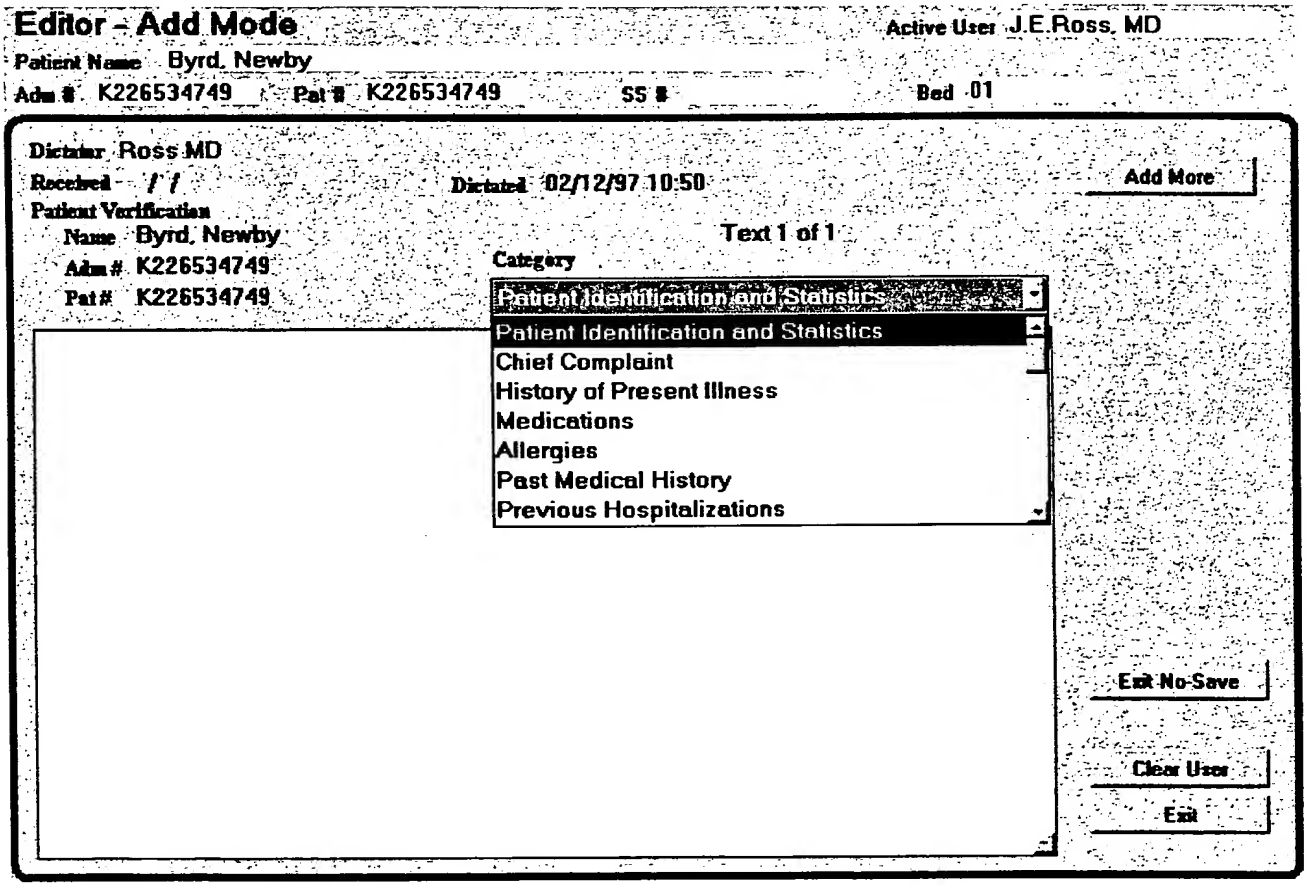


Figure Chapter 3: -46: Previous Hospitalizations (in Editor Add Mode)

(Image: editor-add-mode-1.bmp)

Entering/Modifying Past Hospital Admissions (manual) *(continued)*

4b. Modify an existing Past Hospital Admissions entry:

- Click on Next / Prior (or First / Last) buttons to Previous Hospital Admissions.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

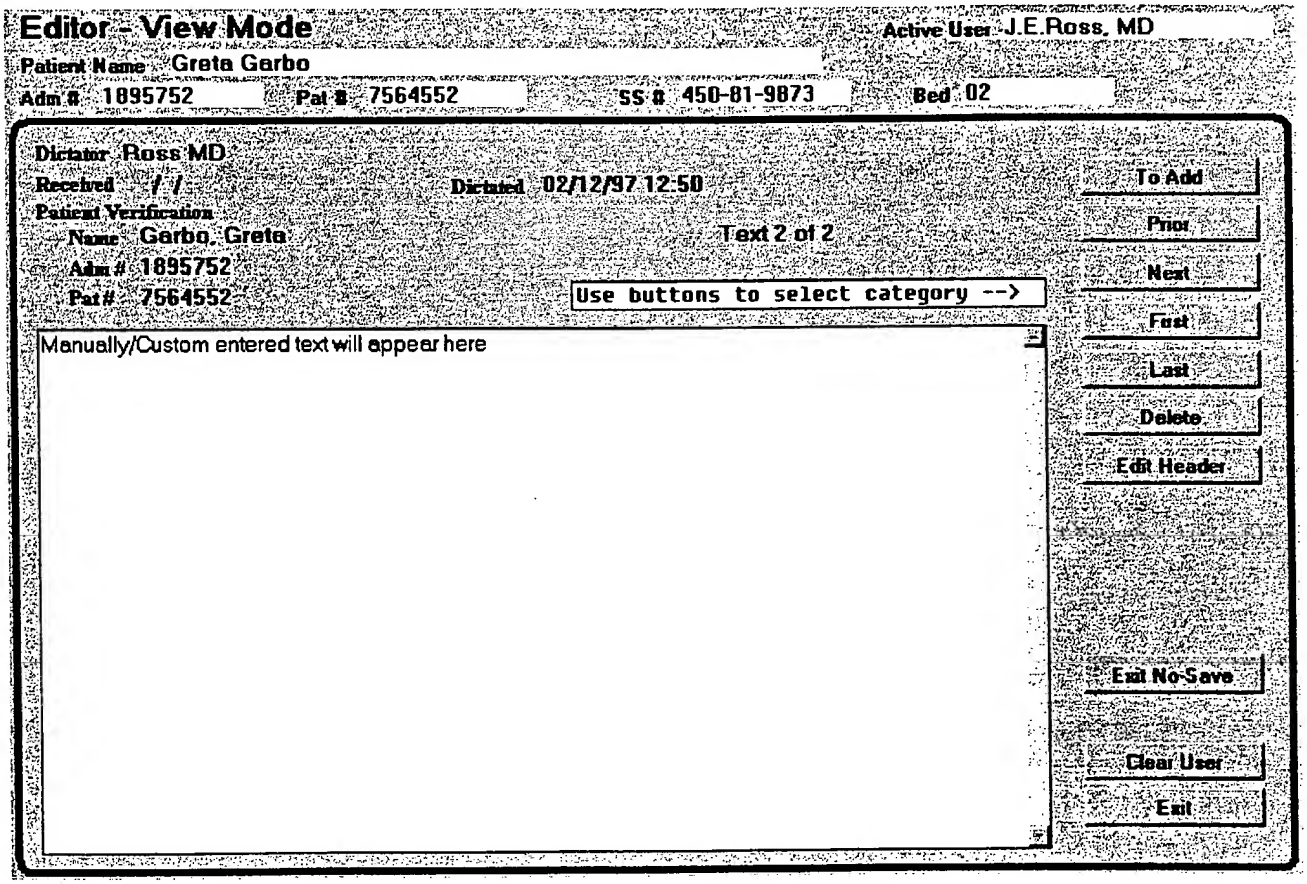


Figure Chapter 3: -47: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

6. Click the Exit button to save updated patient information.

Viewing Past Hospital Admissions

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Summary button in the HISTORICAL section. [brings you to the Medical Record Summary]

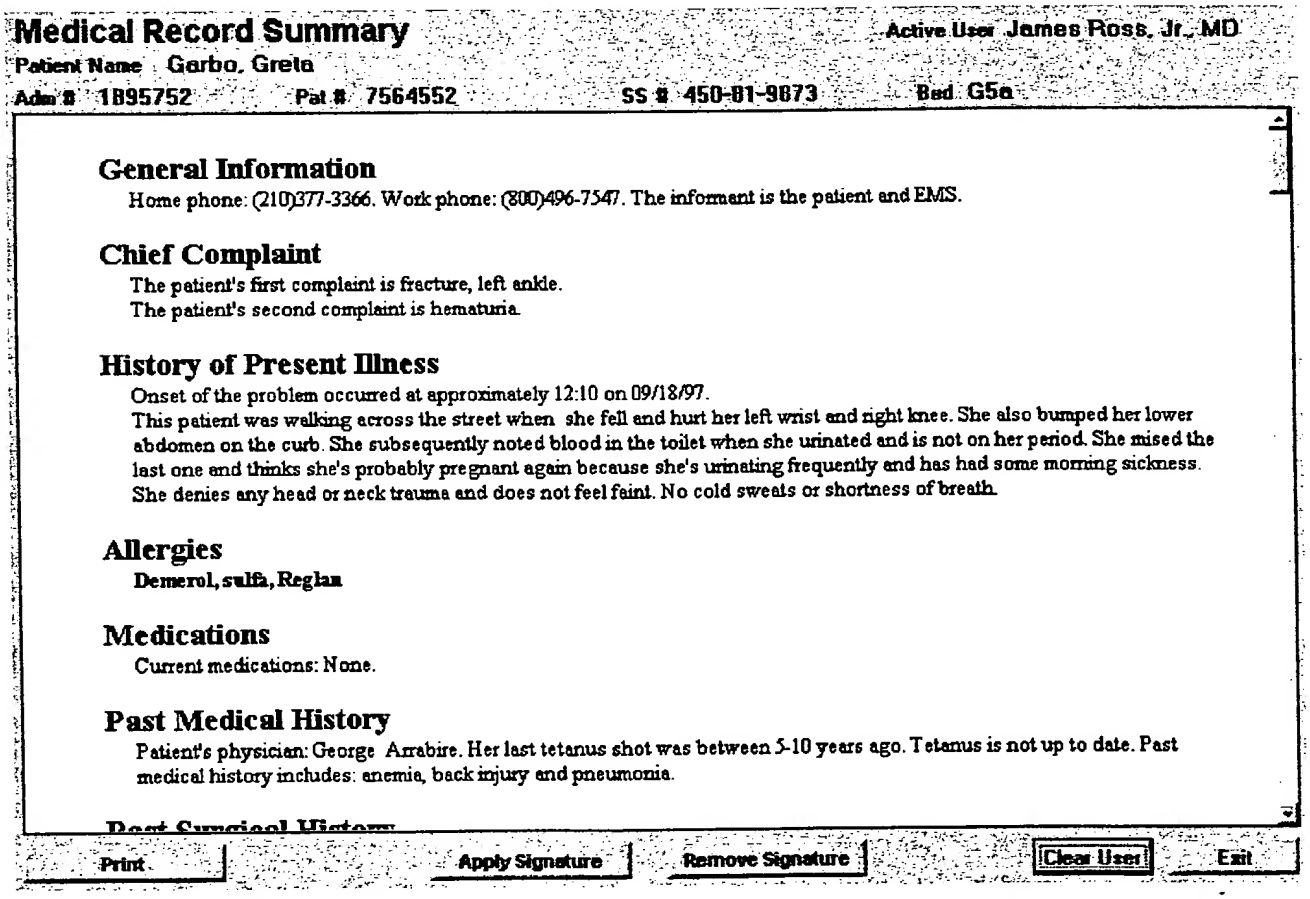
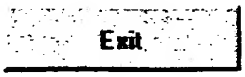


Figure Chapter 3: -48: Medical Record Summary

(Image: medical-record-summary-a.bmp)

4. Click the Scroll Bar to view additional information.



5. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Past Hospital Admissions:

- The **Prephrased Text** function (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Past Hospital Admissions text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.

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Review of Systems

Entering/Modifying Review of Systems (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).
2. Click the Medical Information button.
3. Click on the Review of Systems button in the INPUT section.
4. Complete the Initial 1 & 2 screens (general menu of systems) as appropriate.
5. Select any of the systems listed under "Complete System Review" if more detail is required.

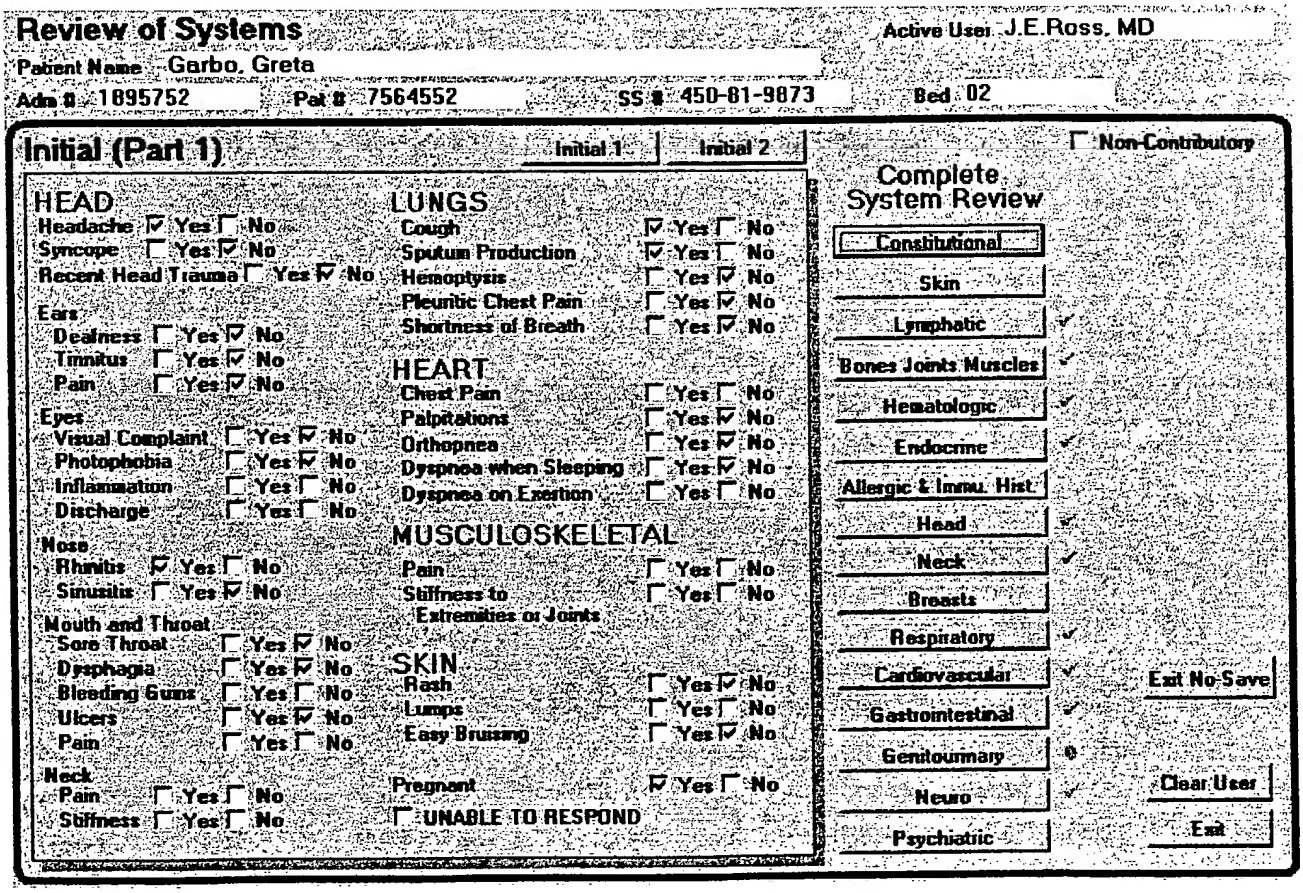


Figure Chapter 3: -49: Review of Systems

(Image: review-of-systems.bmp)

6. Click the Exit button to save updated patient information.

Entering/Modifying Review of Systems (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Transcript Editor button in the HISTORICAL section.

4a) Entering a new Review of Systems entry:

- Click on To Add button.
- Open the pull down menu and select "Review of Systems".

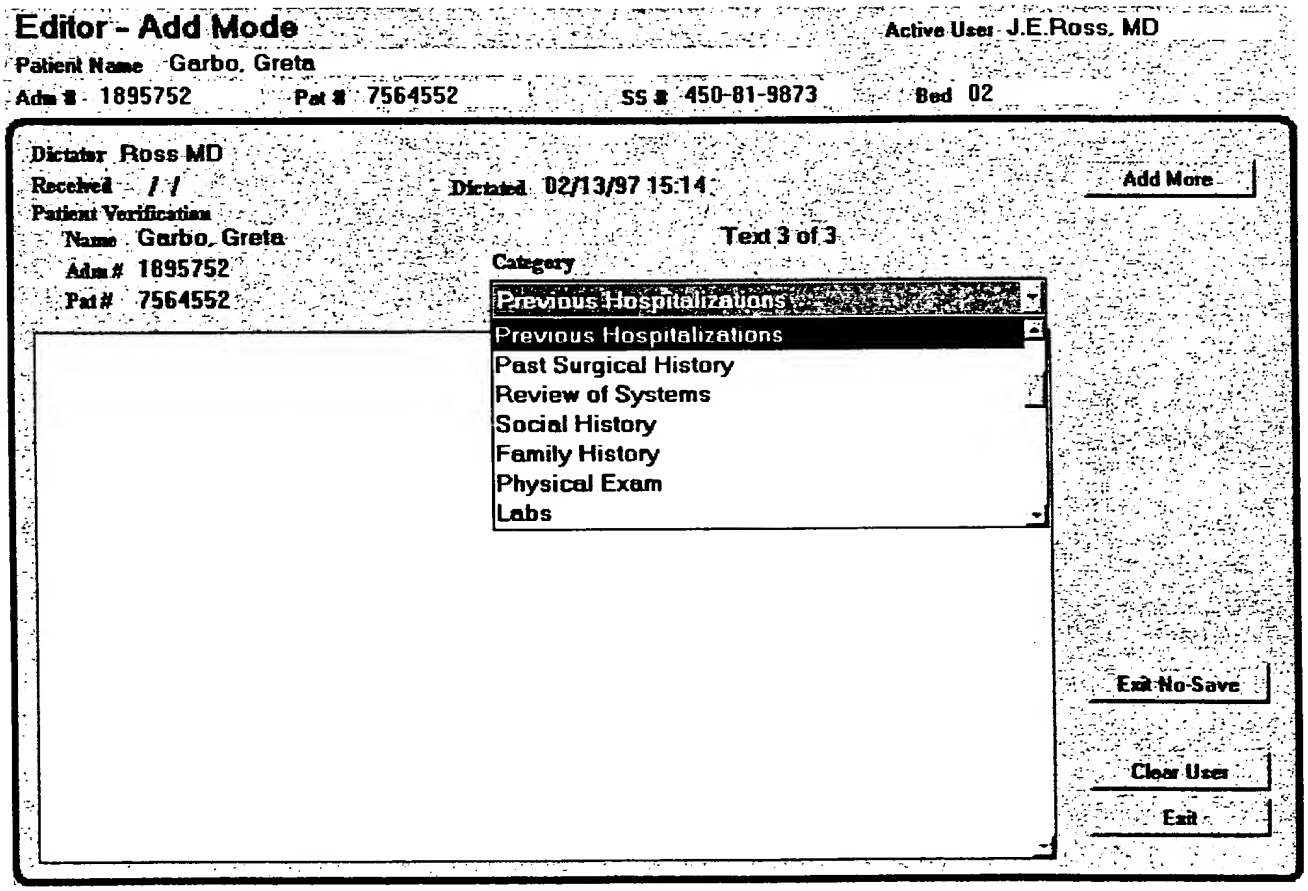


Figure Chapter 3: -50: Review of Systems (in Editor Add Mode)

(Image: editor-add-mode-2.bmp)

Entering/Modifying Review of Systems (manual) *(continued)*

4b. Modify an existing Review of Systems entry:

- Click on Next / Prior (or First / Last) buttons Review of Systems.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

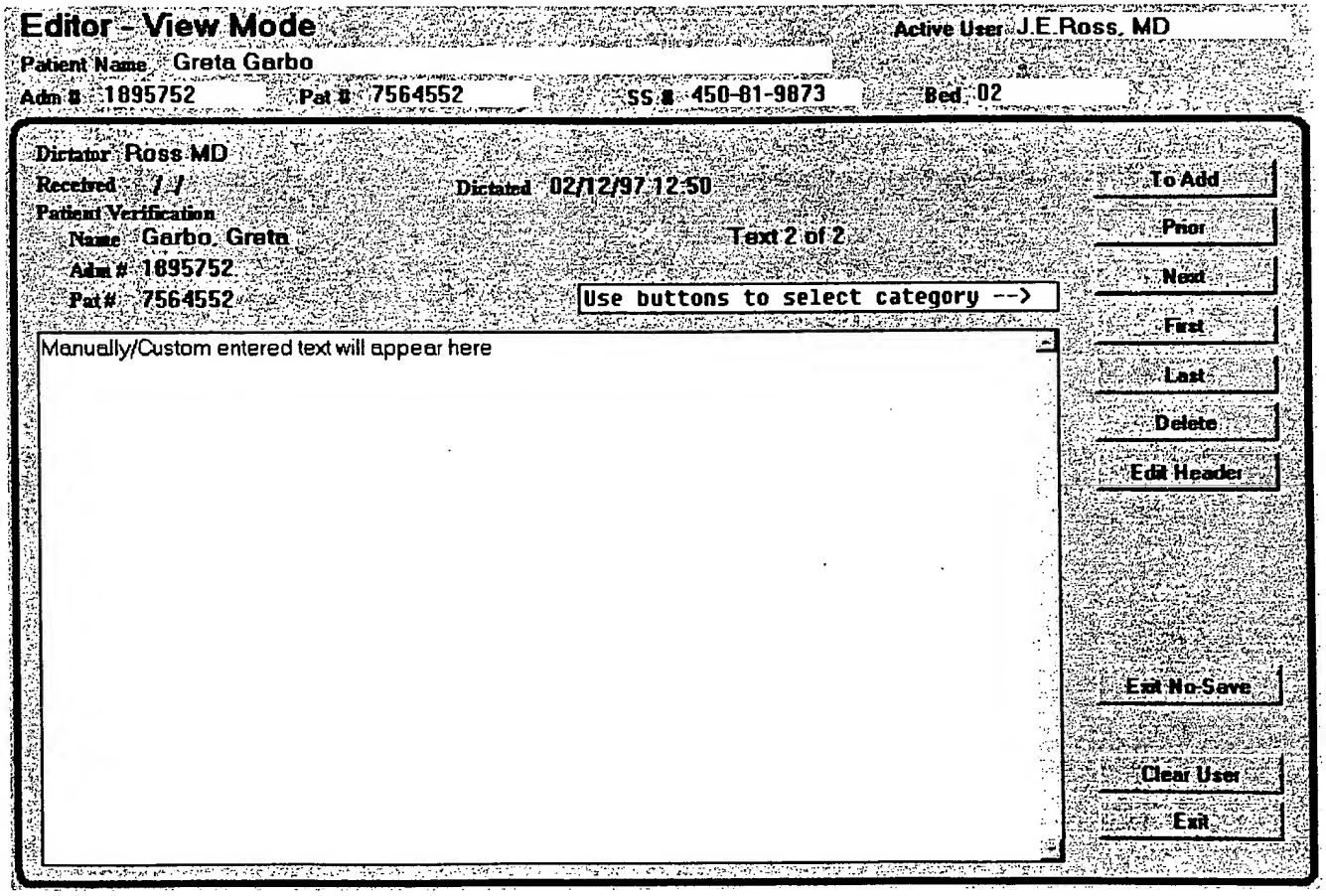
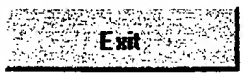


Figure Chapter 3: -51: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)



6. Click the Exit button to save updated patient information.

Viewing Review of Systems

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Summary button in the HISTORICAL section. [brings you to the Medical Record Summary]

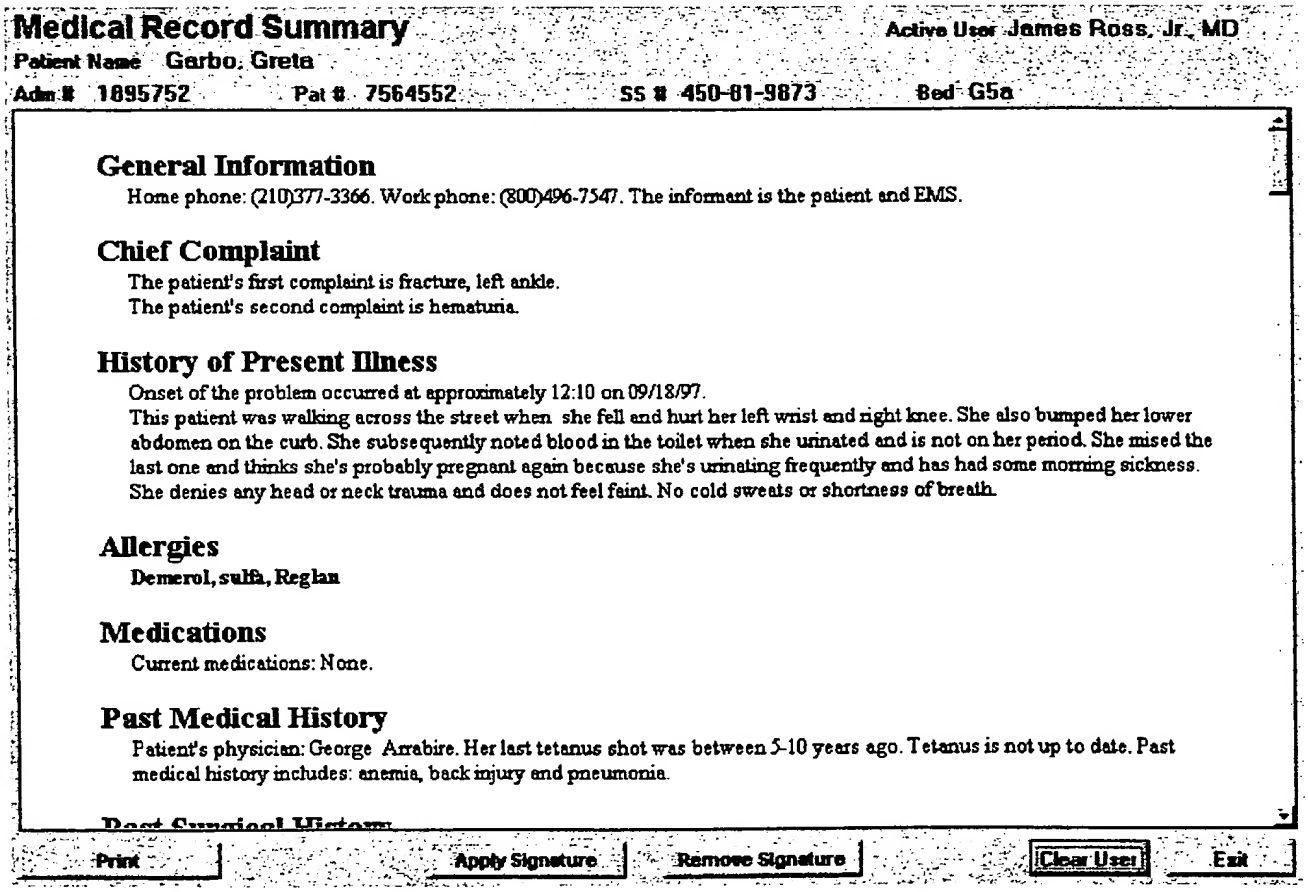


Figure Chapter 3: -52: Medical Record Summary

(Image: medical-record-summary-2.bmp)

4. Click the Scroll Bar to view additional information.

5. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Review of Systems:

- The **Prephrased Text** function (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Review of Systems text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.

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Family History

Entering/Modifying Family History (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Family History

3. Click on the Family History button in the INPUT section.
4. Click on check boxes and form fields to complete as appropriate.

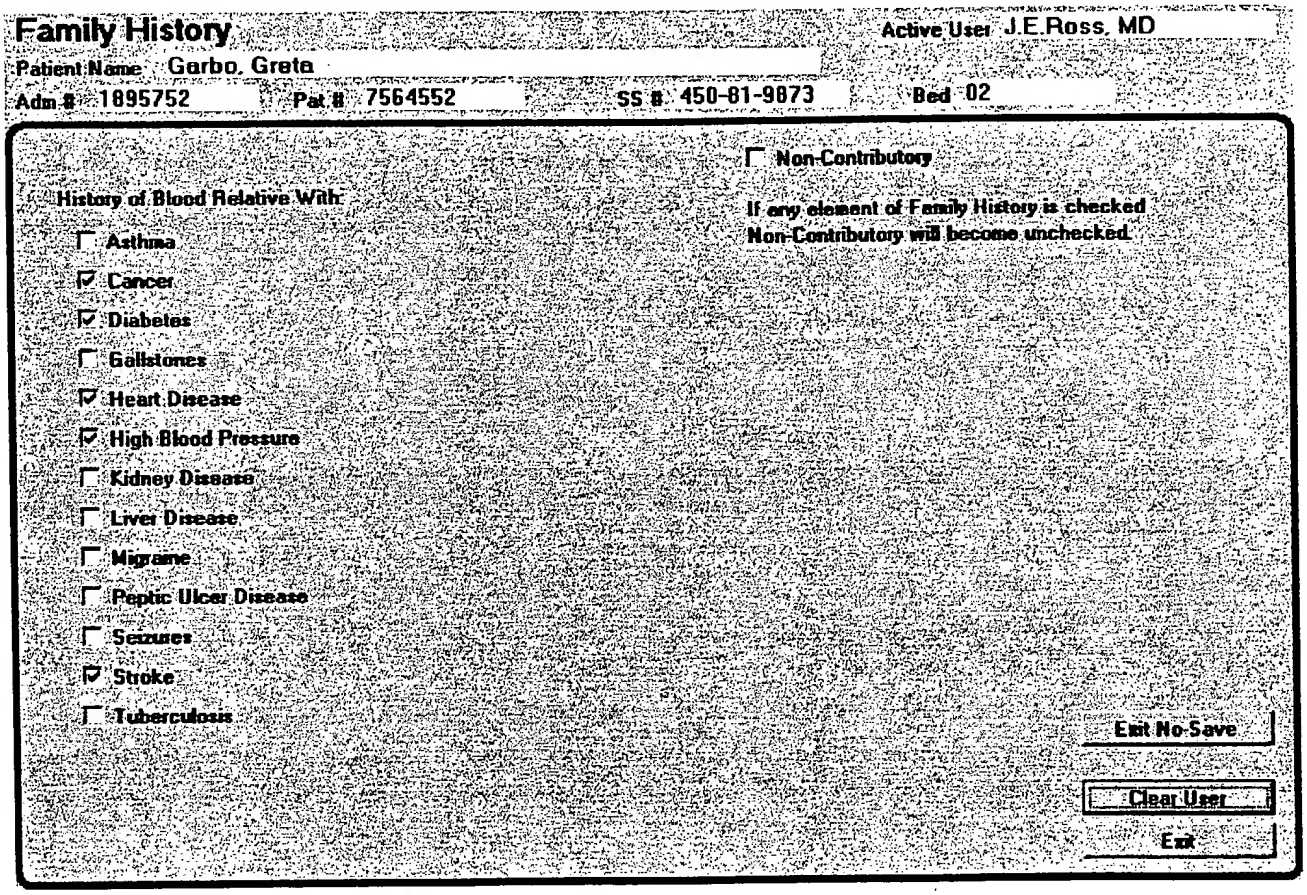


Figure Chapter 3: -53: Family History

(Image: family-history.bmp)

Exit

5. Click the Exit button to save updated patient information.

Entering/Modifying Family History (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Transcript Editor button in the HISTORICAL section.

4a) Entering a new Family History entry:

- Click on To Add button.
- Open the pull down menu and select "Family History".

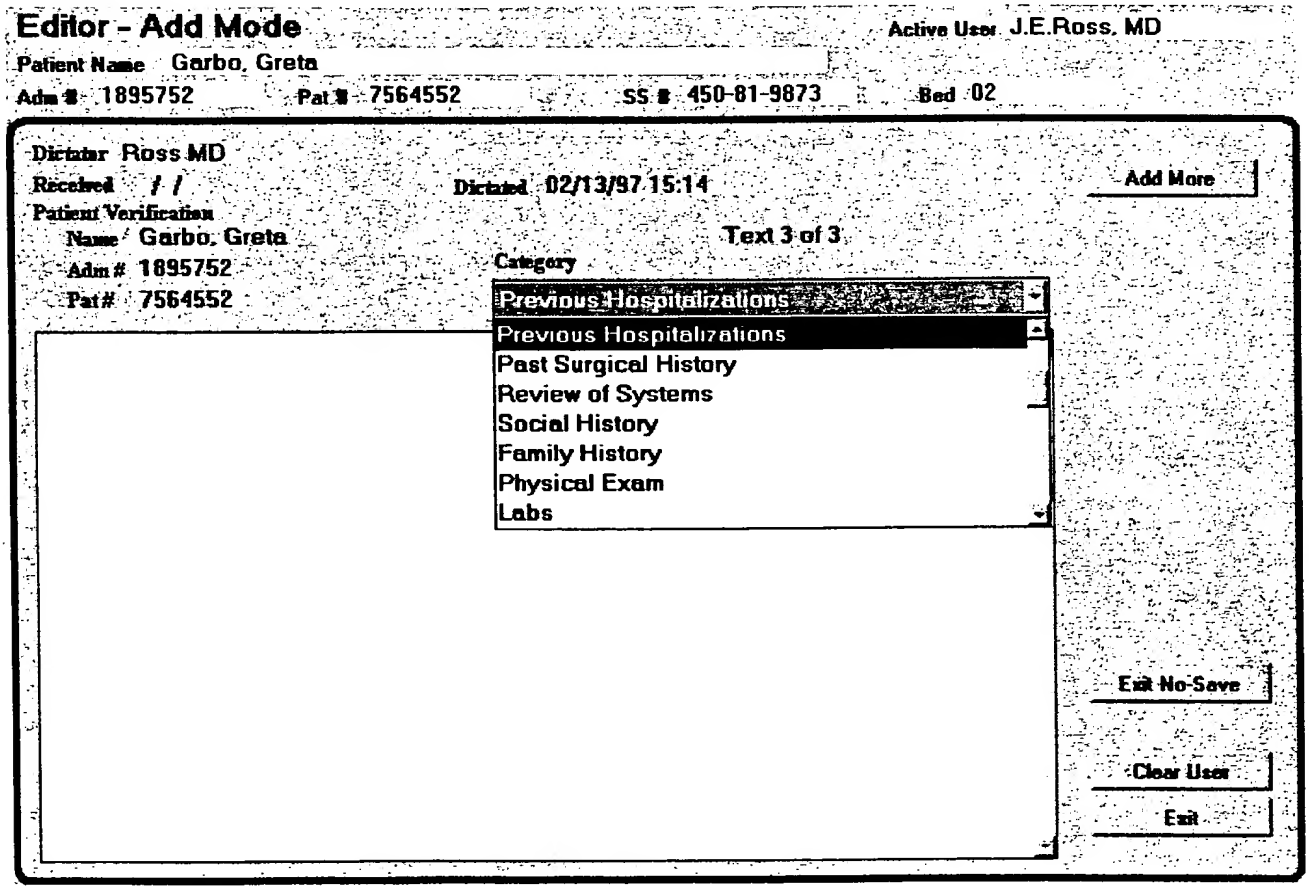


Figure Chapter 3: -54: Family History (in Editor Add Mode)

(Image: editor-add-mode-2.bmp)

Entering/Modifying Family History (manual) *(continued)*

4b. Modify an existing Family History entry:

- Click on Next / Prior (or First / Last) buttons to locate Family History.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

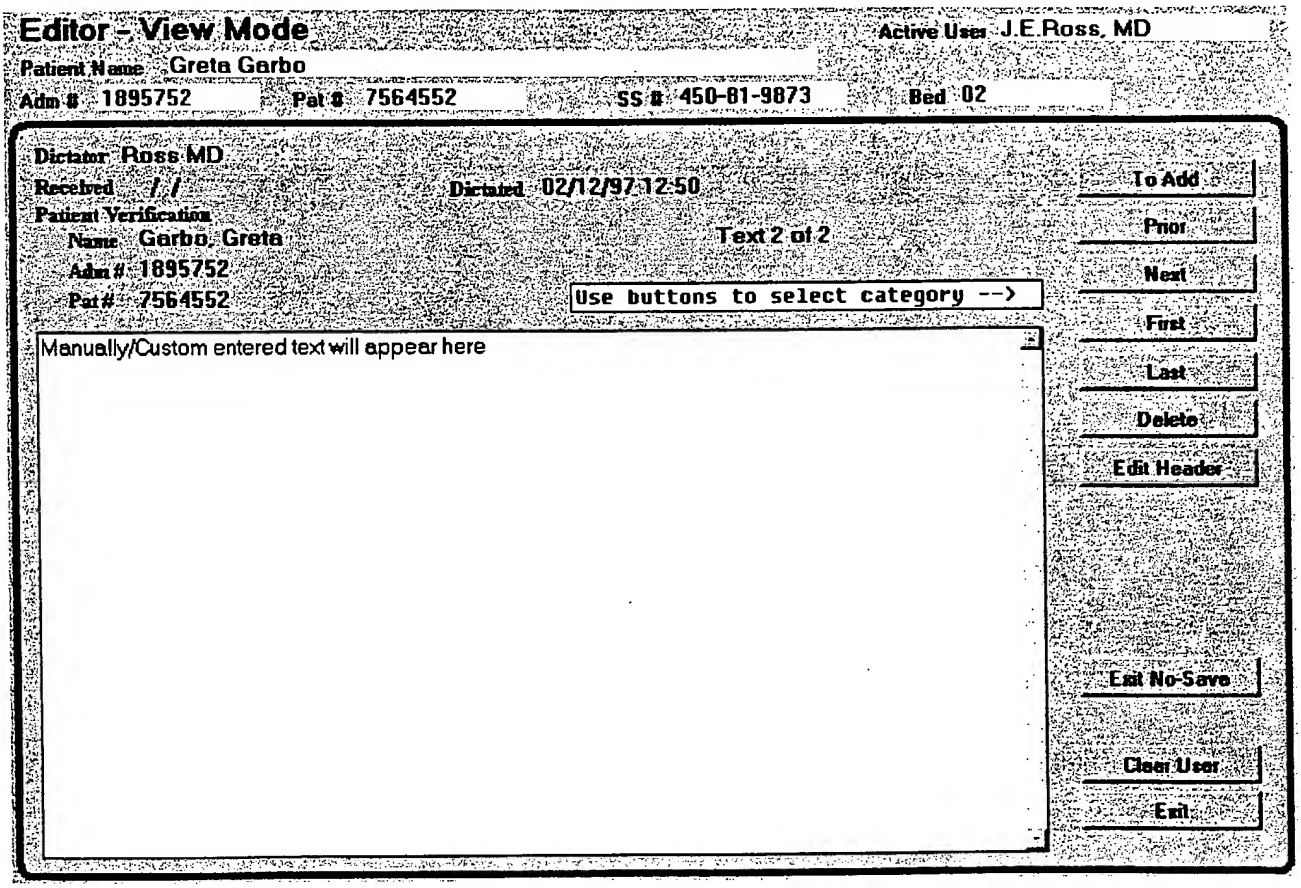


Figure Chapter 3: -55: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

6. Click the Exit button to save updated patient information.

Viewing Family History

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Summary button in the HISTORICAL section. [brings you to the Medical Record Summary]

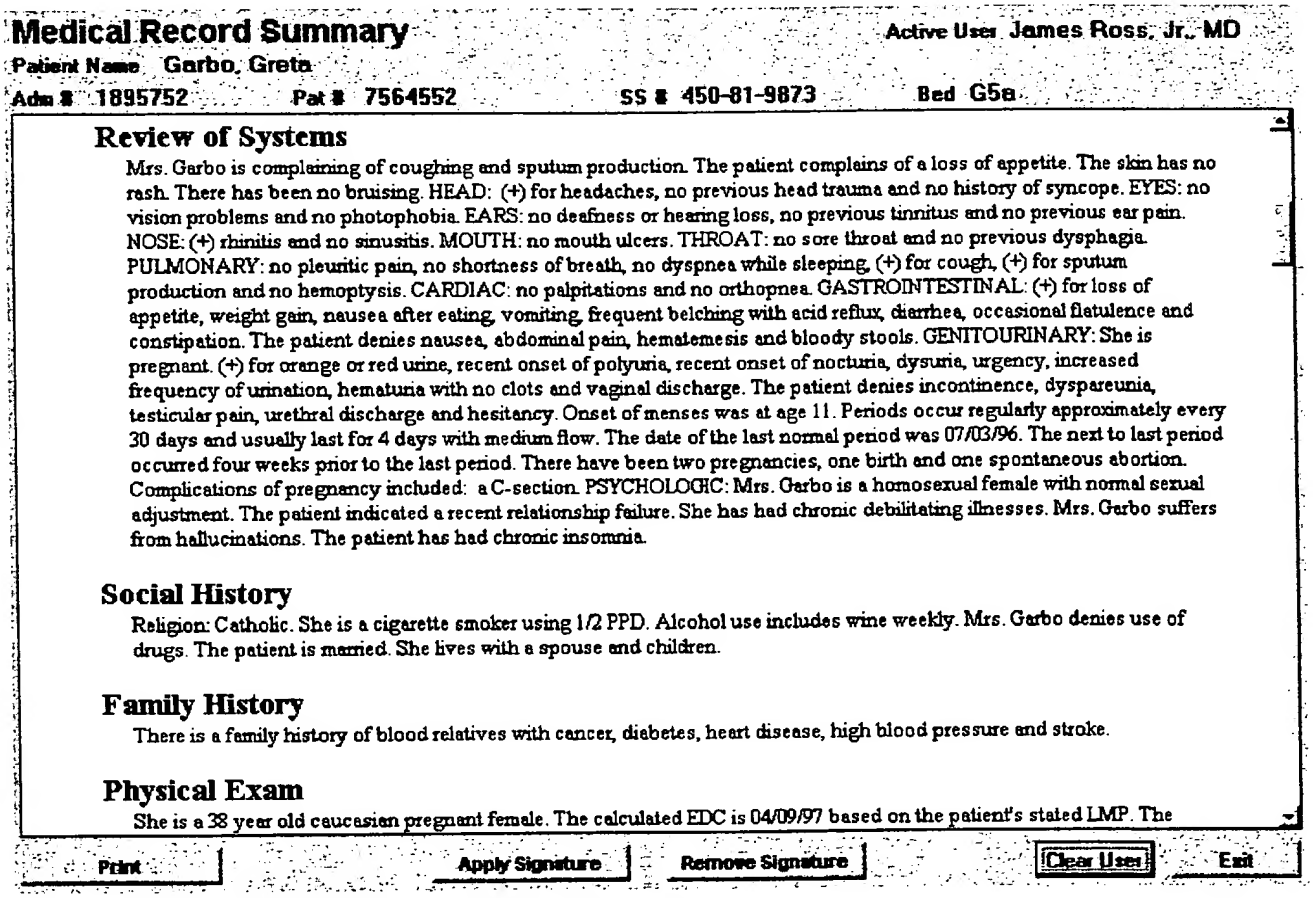
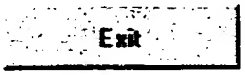


Figure Chapter 3: -56: Medical Record Summary

(Image: medical-record-summary-2.bmp)

4. Click the Scroll Bar to view additional information.



5. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Family History:

- The **Prephrased Text** function (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Family History text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.

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Social History

Entering/Modifying Social History (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Social History button in the INPUT section.
4. Click on check boxes and form fields to complete as appropriate.

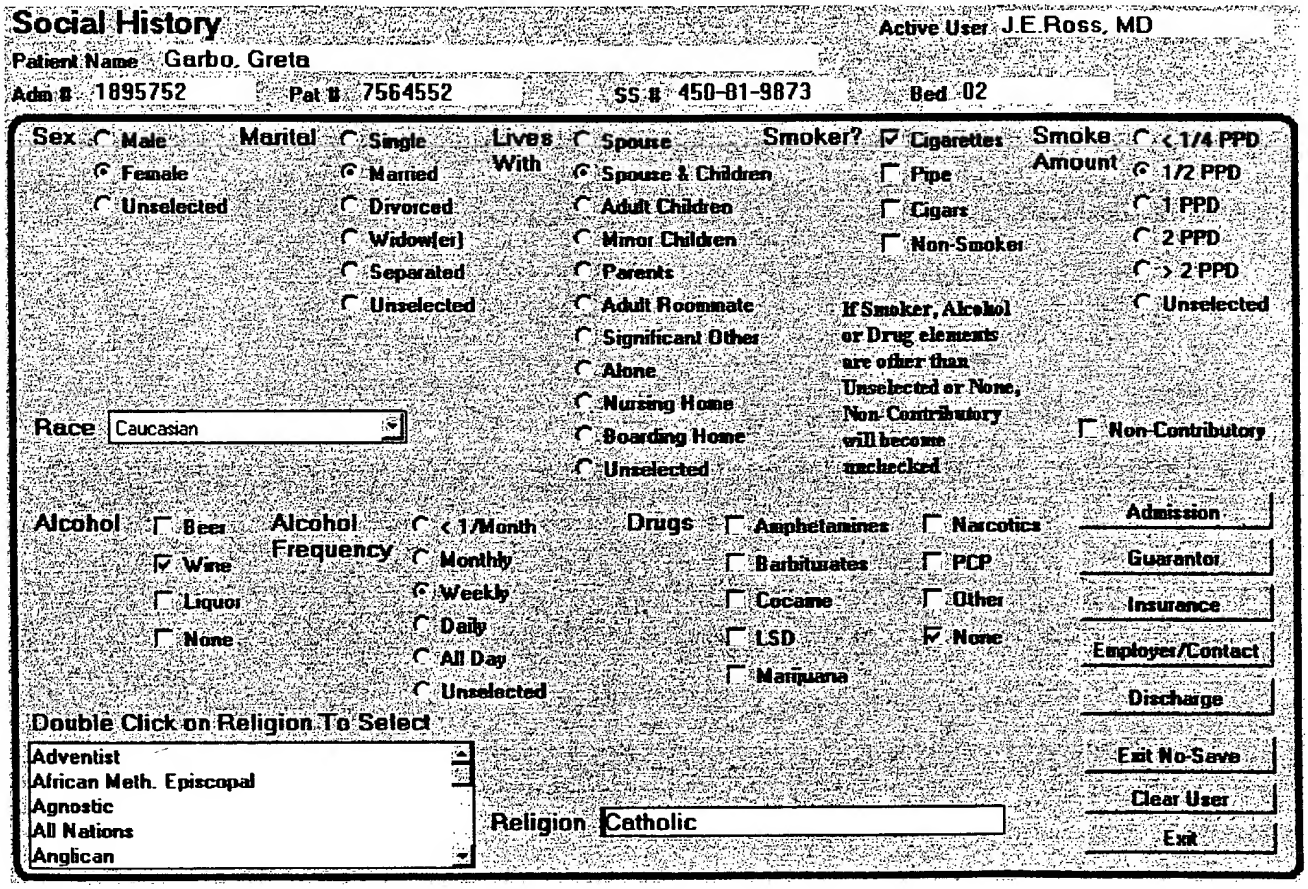


Figure Chapter 3: -57: Social History

(Image: social-history.bmp)

5. Click the Exit button to save updated patient information.

Entering/Modifying Social History (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Transcript Editor button in the HISTORICAL section.

4a) Entering a new Social History entry:

- Click on To Add button.
- Open the pull down menu and select "Social History".

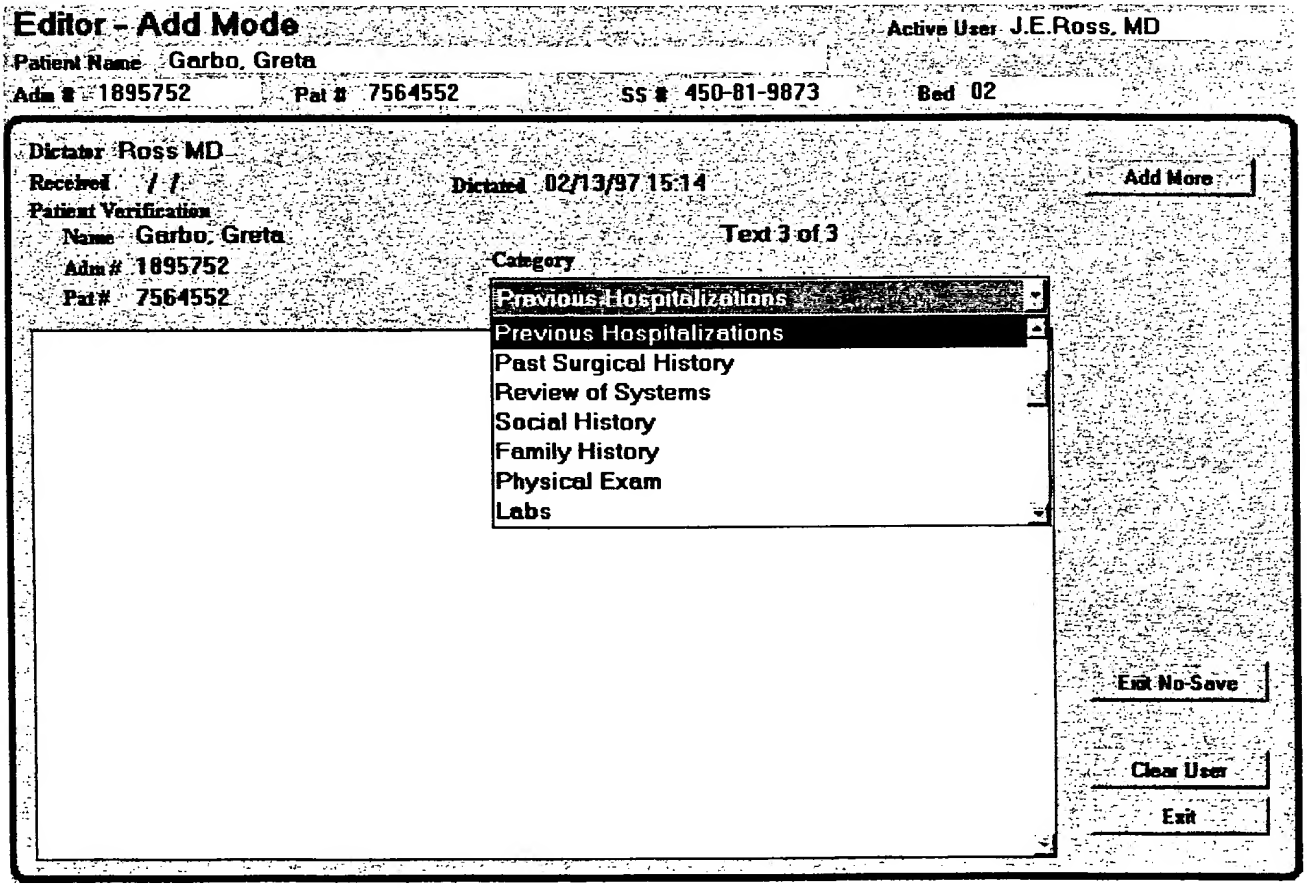


Figure Chapter 3: -58: Social History (in Editor Add Mode)

(Image: editor-add-mode-2.bmp)

Entering/Modifying Social History (manual) *(continued)*

4b. Modify an existing Social History entry:

- Click on Next / Prior (or First / Last) buttons to locate Social History.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

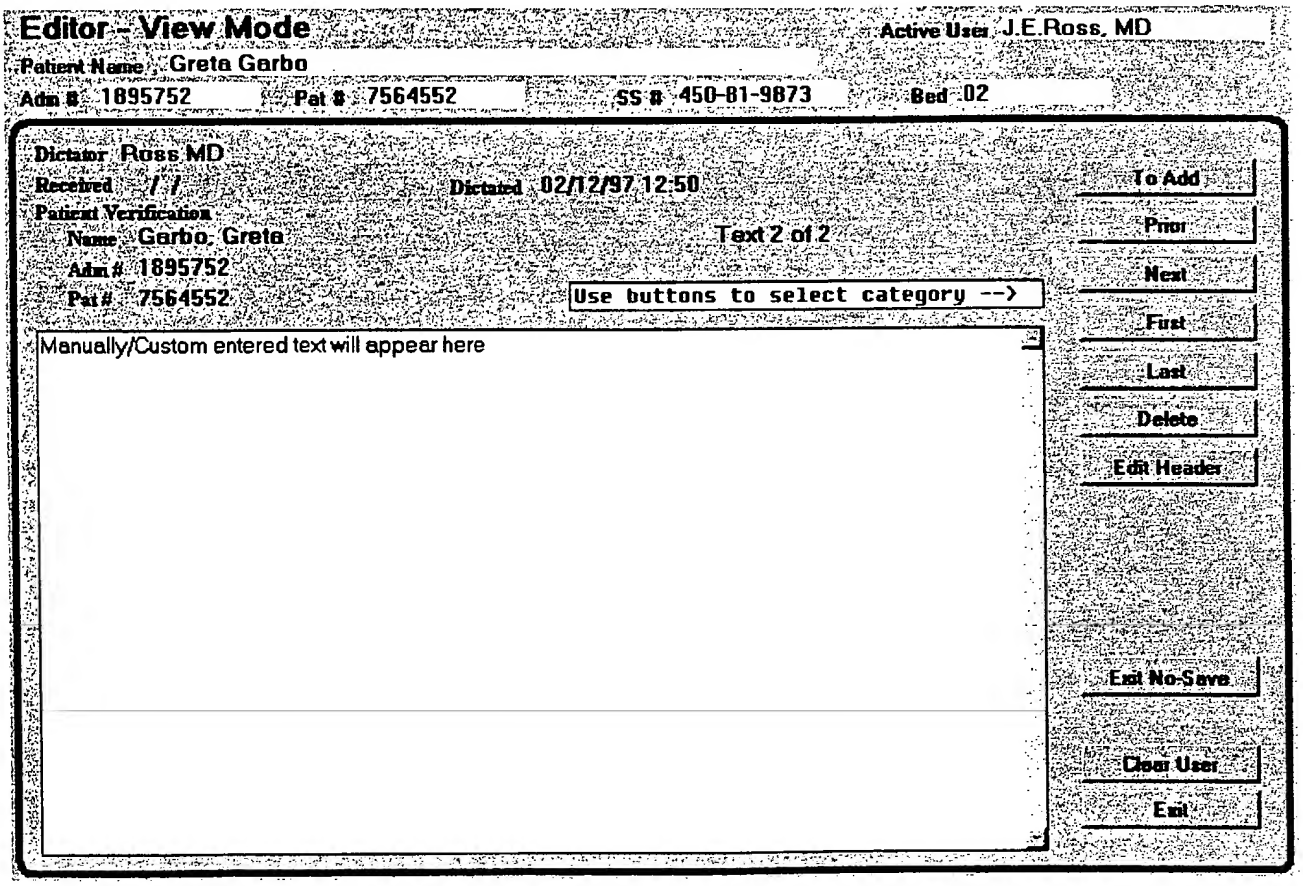
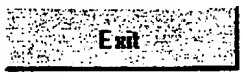


Figure Chapter 3: -59: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)



6. Click the Exit button to save updated patient information.

Viewing Social History

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Summary

3. Click on the Summary button in the HISTORICAL section. [brings you to the Medical Record Summary]

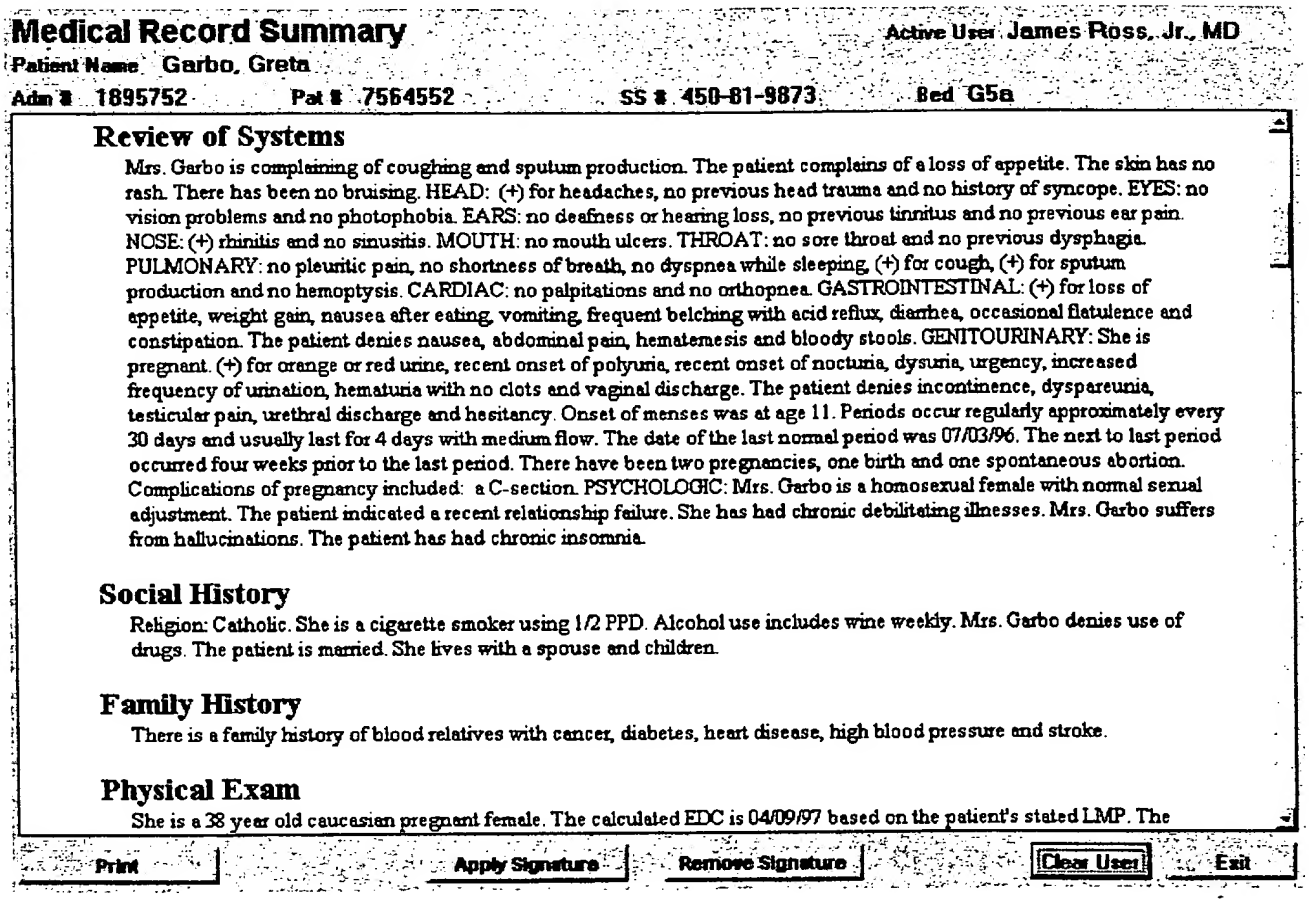


Figure Chapter 3: -60: Medical Record Summary

(Image: medical-record-summary-2.bmp)

4. Click the Scroll Bar to view additional information.

Exit

5. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Social History:

- The **Prephrased Text** function (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Social History text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.

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Patient Allergies

Entering/Modifying Patient Allergies (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Allergies button in the INPUT section.
4. Complete the screen as appropriate. If no allergies, click None button.

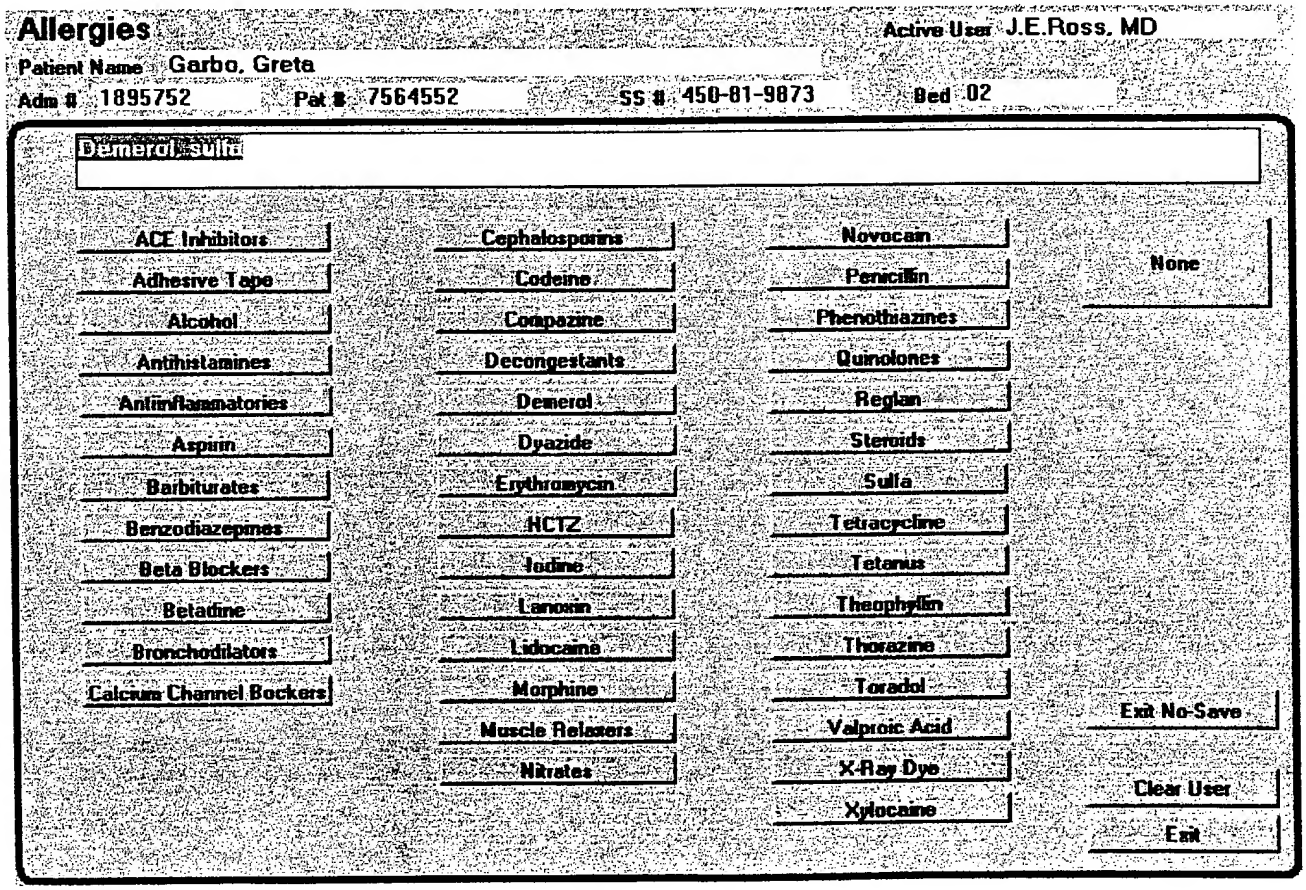


Figure Chapter 3: -61: Allergies

(Image: allergies.bmp)

5. Click the Exit button to save updated patient information.

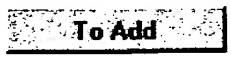
Entering/Modifying Patient Allergies (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Transcript Editor button in the HISTORICAL section.



4a) Entering a new Allergies entry:

- Click on To Add button.
- Open the pull down menu and select "Allergies".

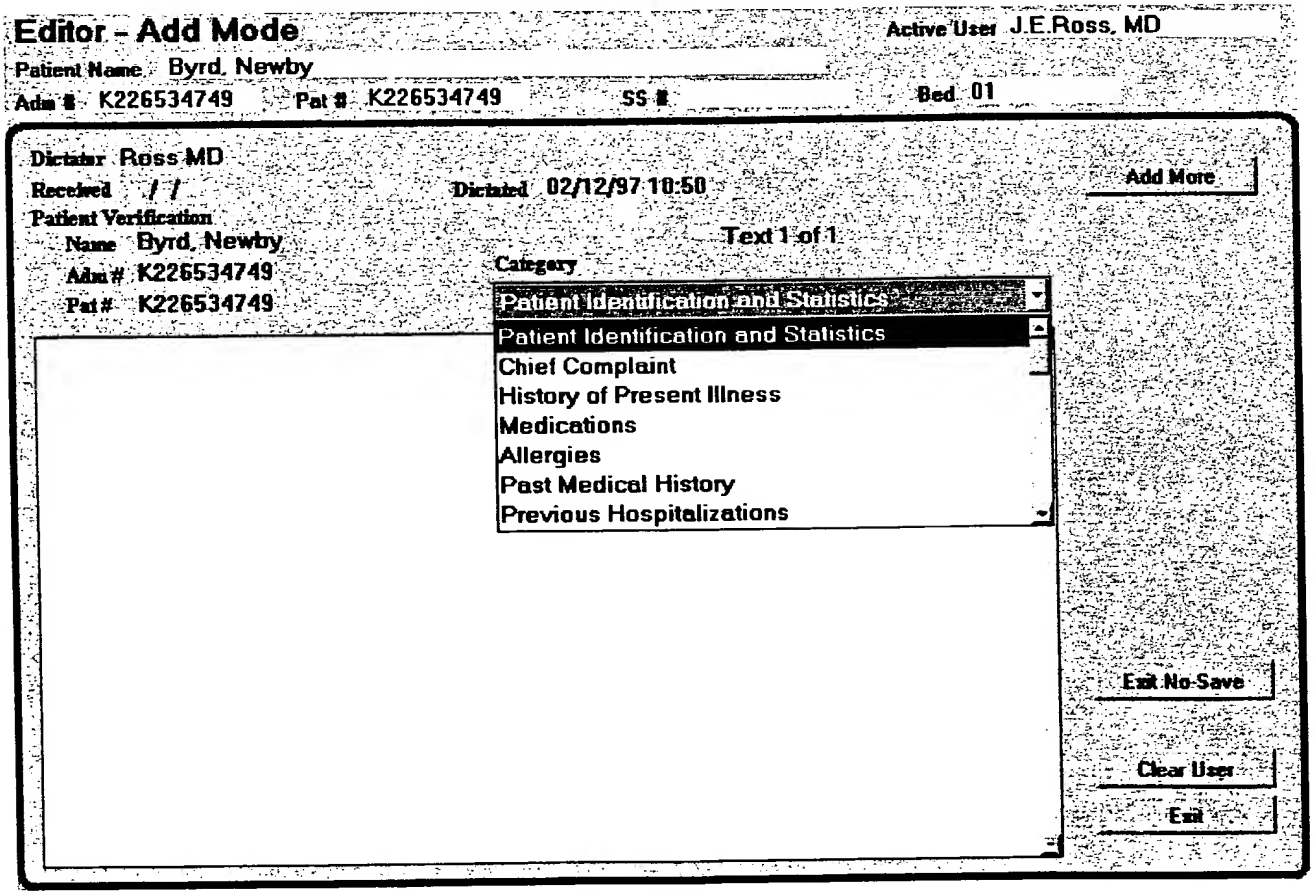


Figure Chapter 3: -62: Allergies (in Editor Add Mode)

(Image: editor-add-mode-1.bmp)

Entering/Modifying Allergies (manual) *(continued)*

4b. Modify an existing Allergies entry:

- Click on Next / Prior (or First / Last) buttons to Allergies.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

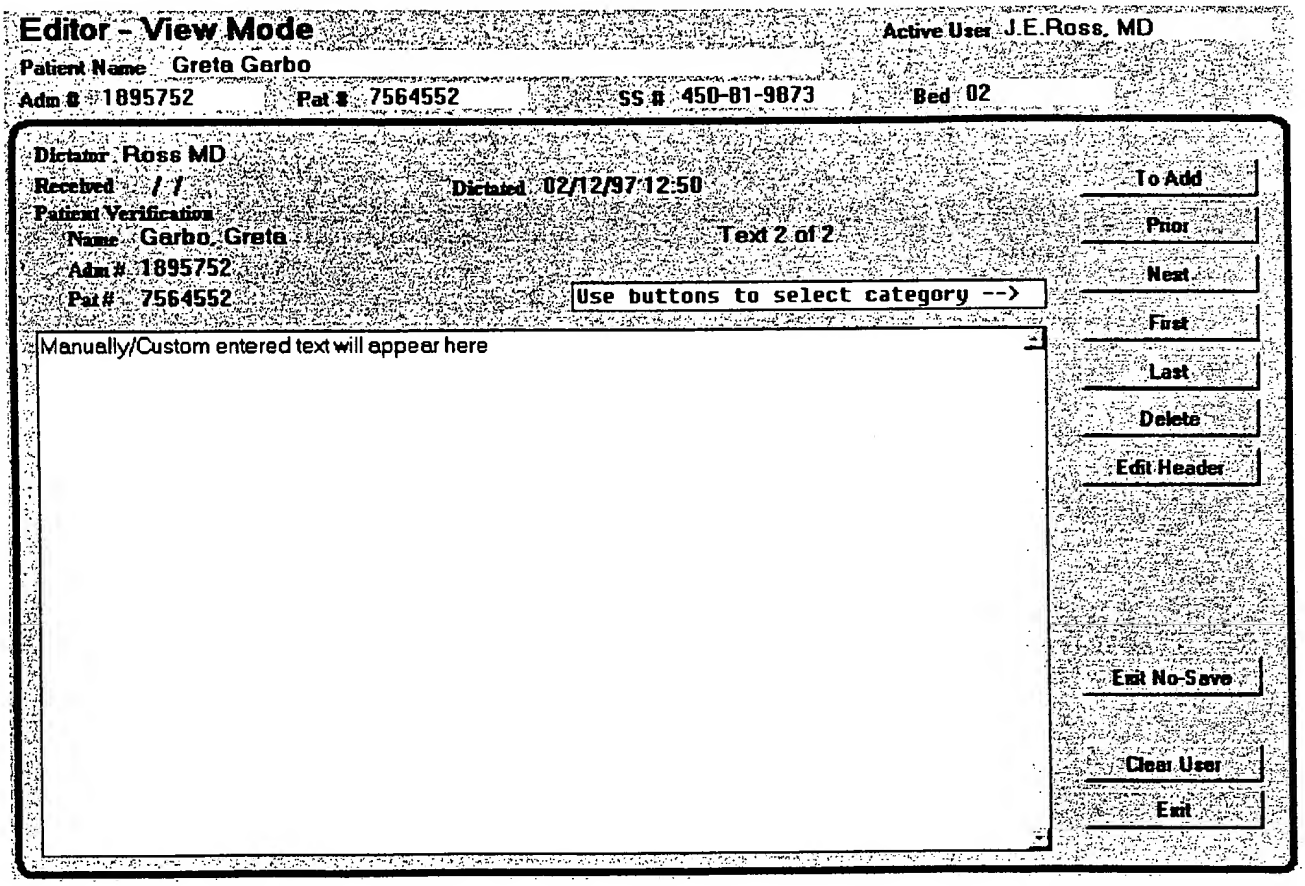


Figure Chapter 3: -63: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

6. Click the Exit button to save updated patient information.

Viewing Patient Allergies

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).
2. Click the Medical Information button.
3. Click on the Summary button in the HISTORICAL section. [brings you to the Medical Record Summary]

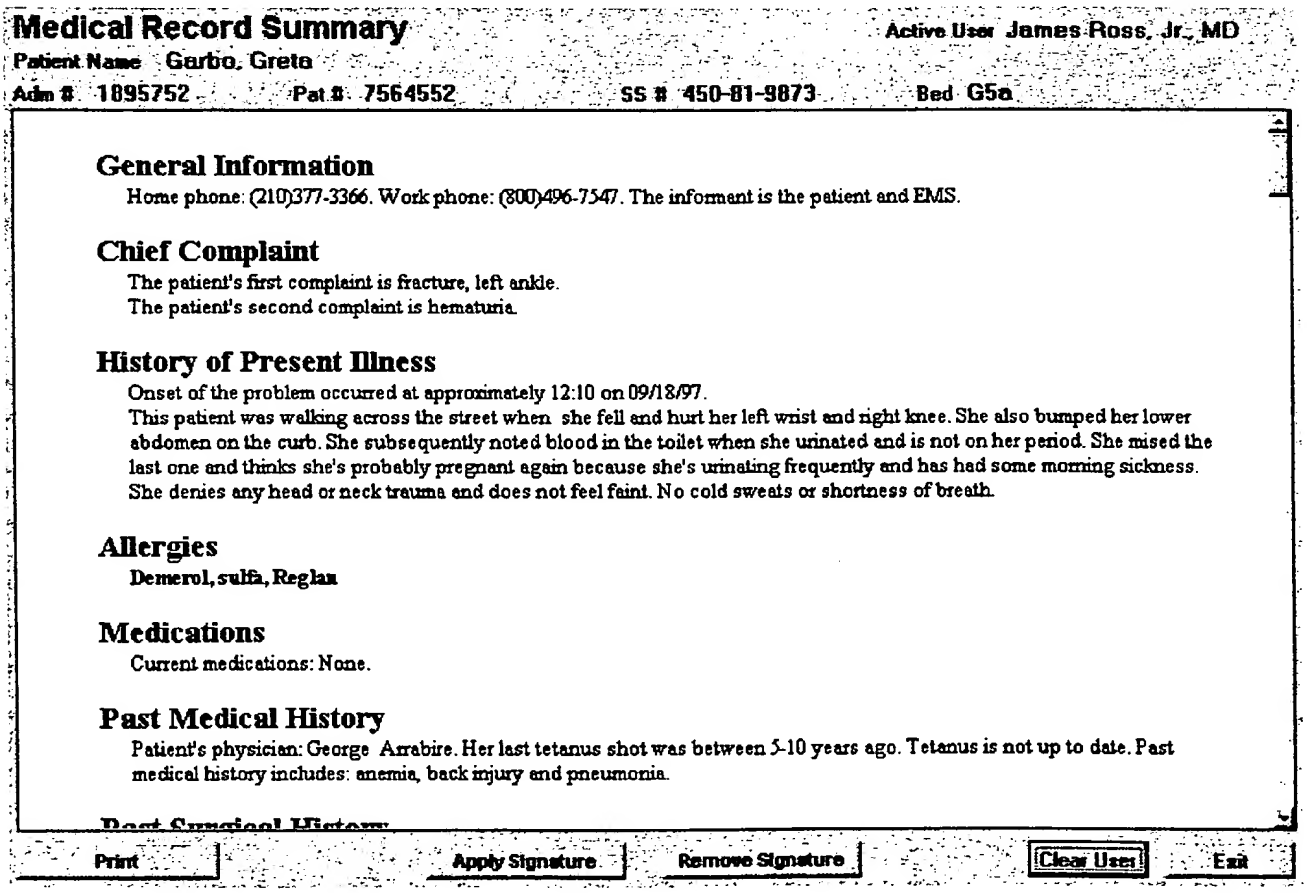


Figure Chapter 3: -64: Medical Record Summary

(Image: medical-record-summary.bmp)

4. Click the Scroll Bar to view additional information.
5. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Allergies:

- The **Prephrased Text** function (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Allergies text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.

Physical Examination

Entering/Modifying Physical Examination (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Transcript Editor button in the HISTORICAL section.

4a) Entering a new Physical Examination entry:

- Click on To Add button.
- Open the pull down menu and select "Physical Exam".

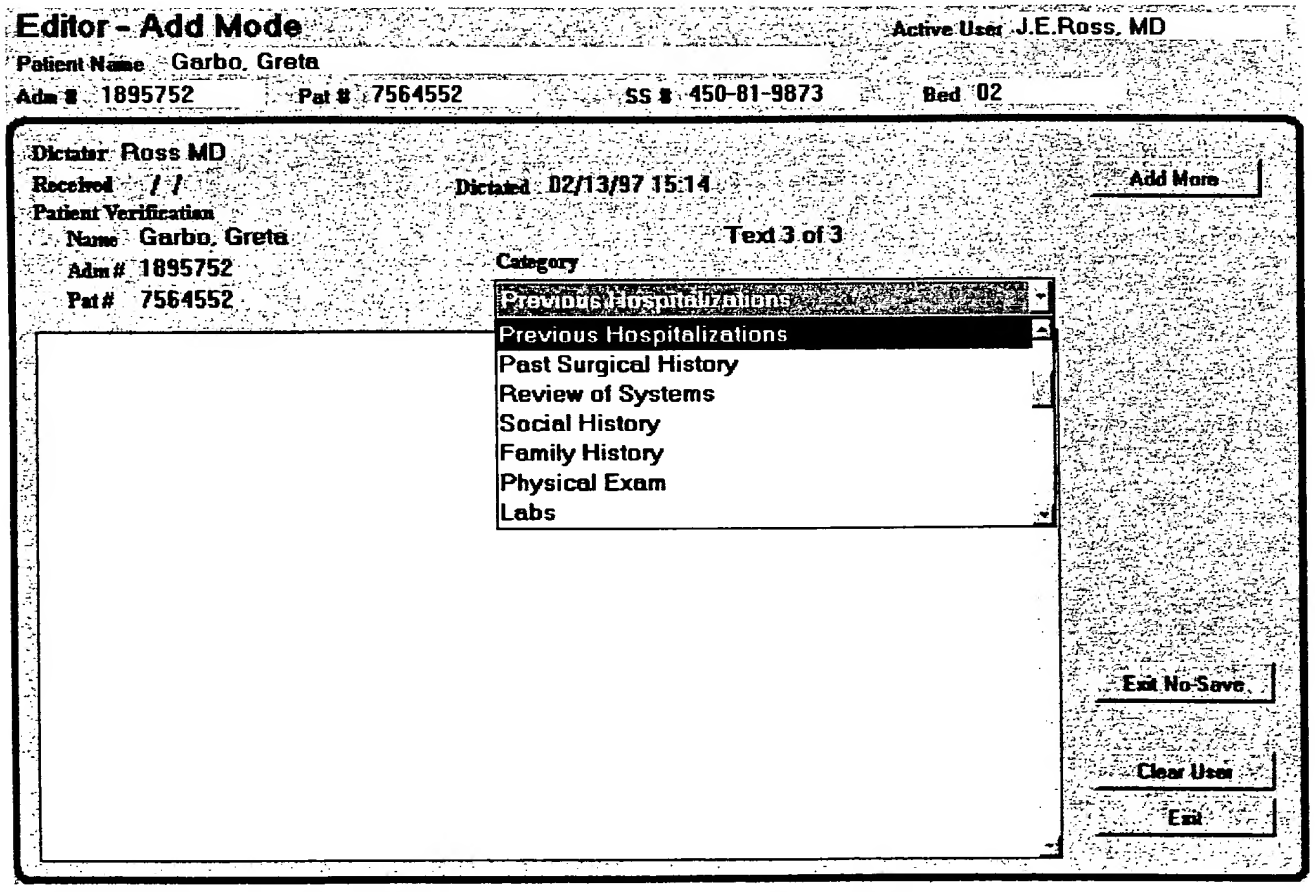
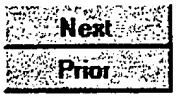


Figure Chapter 3: -65: Physical Exam (in Editor Add Mode)

(Image: editor-add-mode-2.bmp)

Entering/Modifying Physical Examination (manual) *(continued)*



4b. Modify an existing Physical Examination entry:

- Click on Next / Prior (or First / Last) buttons to locate Physical Exam.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

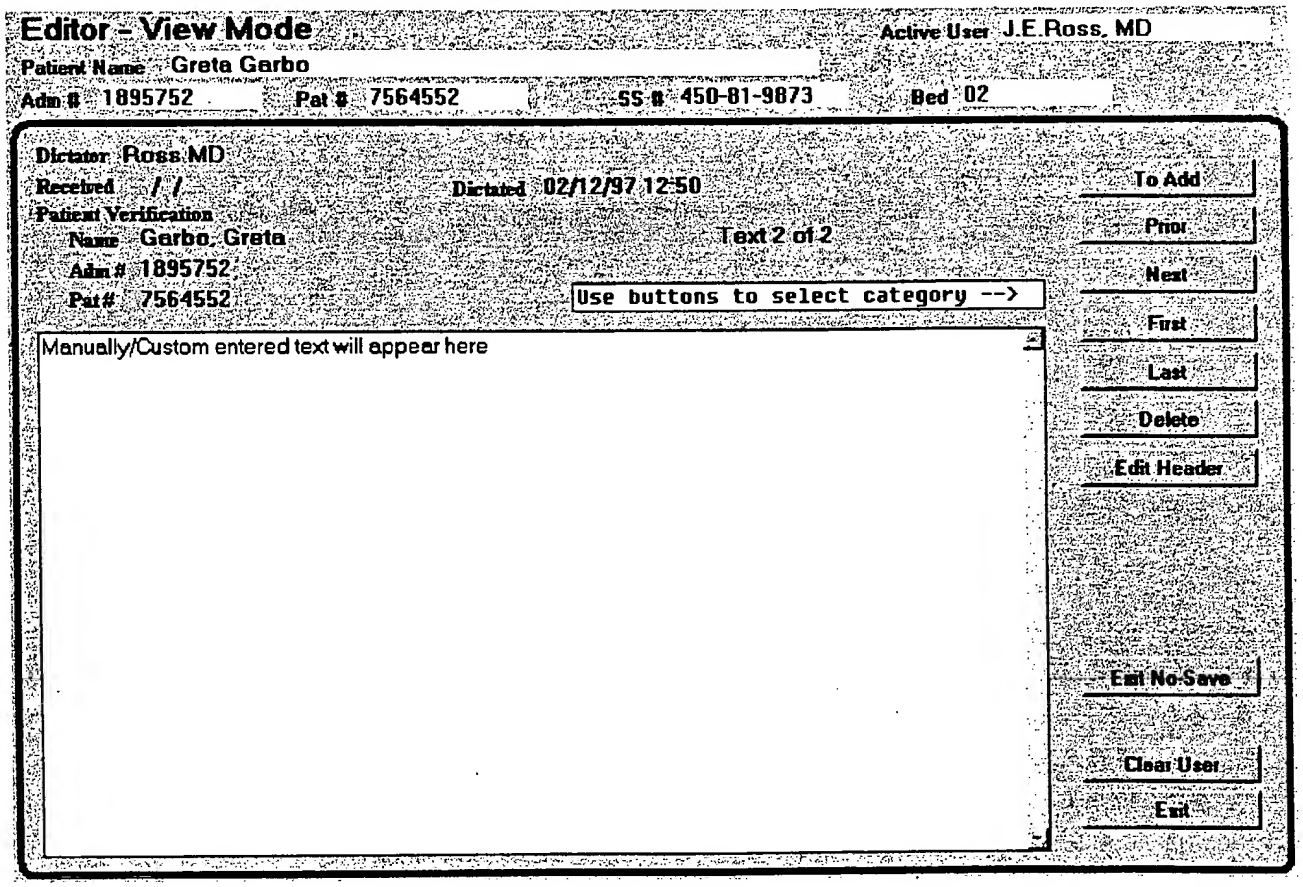


Figure Chapter 3: -66: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

6. Click the Exit button to save updated patient information.

Viewing Physical Examination

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Summary button in the HISTORICAL section. [brings you to the Medical Record Summary]

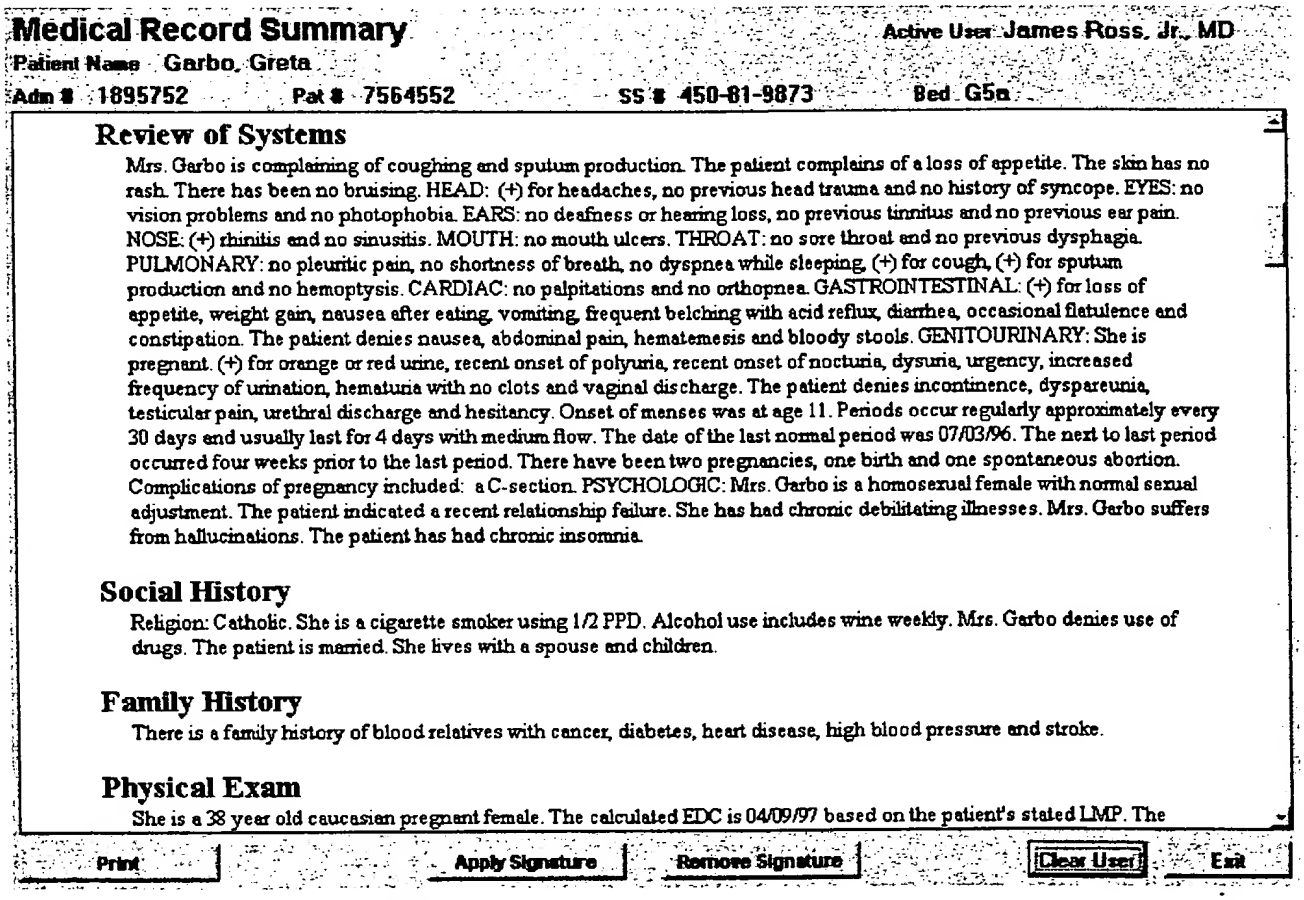


Figure Chapter 3: -67: Medical Record Summary

(Image: medical-record-summary-2.bmp)

4. Click the Scroll Bar to view additional information.

5. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Physical Examination

- The **Prephrased Text function** (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Physical Exam text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.

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TeleMed Patient Dictation, Diagnosis and Clinical Management (Doctors and Nurses)

Differential Diagnosis

Entering/Modifying Differential Diagnosis (std. menu)

*From the "Active Patient List" (your main tracking screen)**

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Differential Diagnosis button in the INPUT section.

4. Add and Delete differential diagnosis as required (follow on-screen instructions).

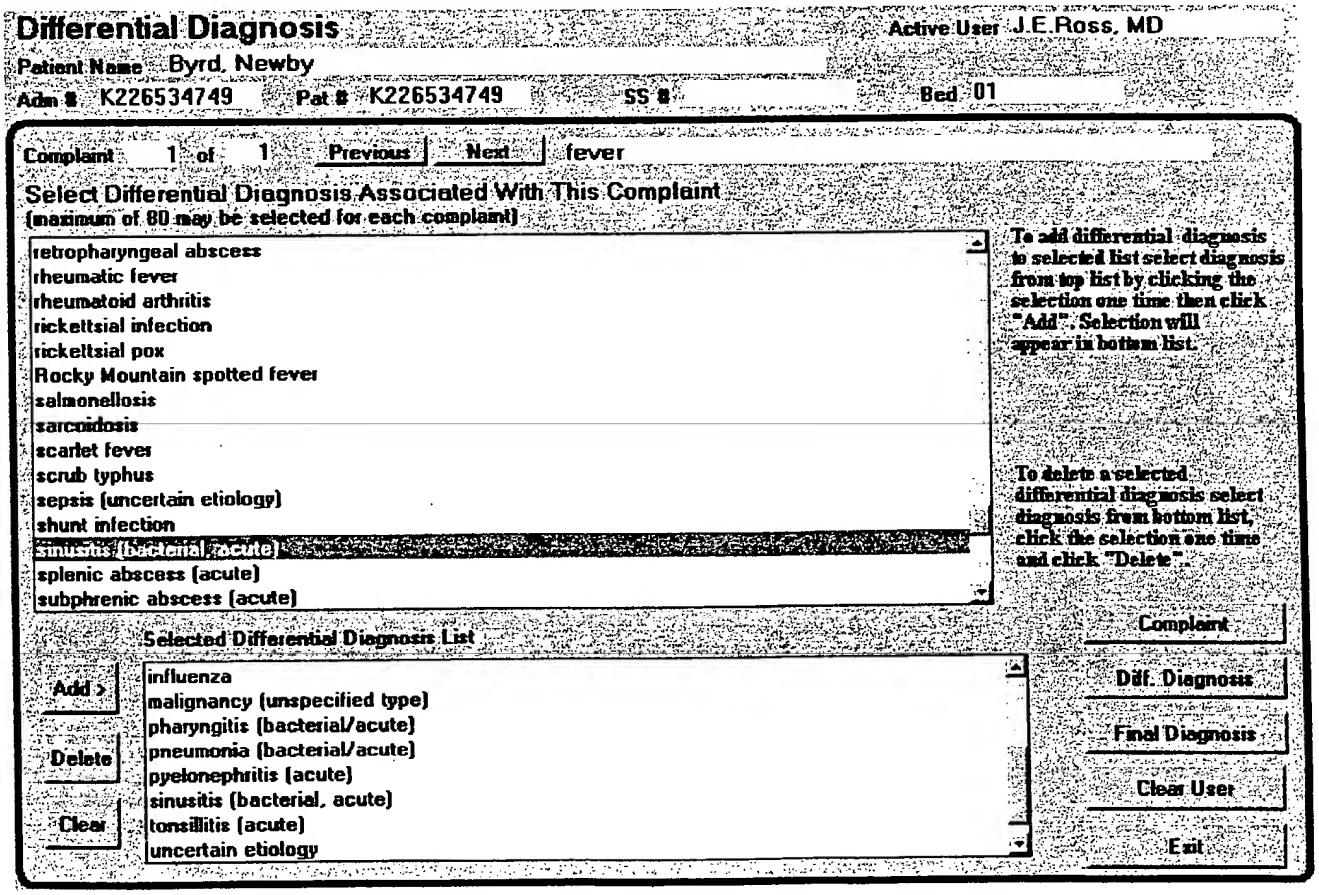


Figure Chapter 3: -68: Differential Diagnosis
(Image: differential-diagnosis.bmp)

5. Click the Exit button to save updated patient information.

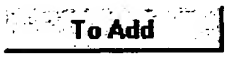
Entering/Modifying Differential Diagnosis (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Transcript Editor button in the HISTORICAL section.



4a) Entering a new Differential Diagnosis entry:

- Click on To Add button.
- Open the pull down menu and select "Differential Diagnosis".

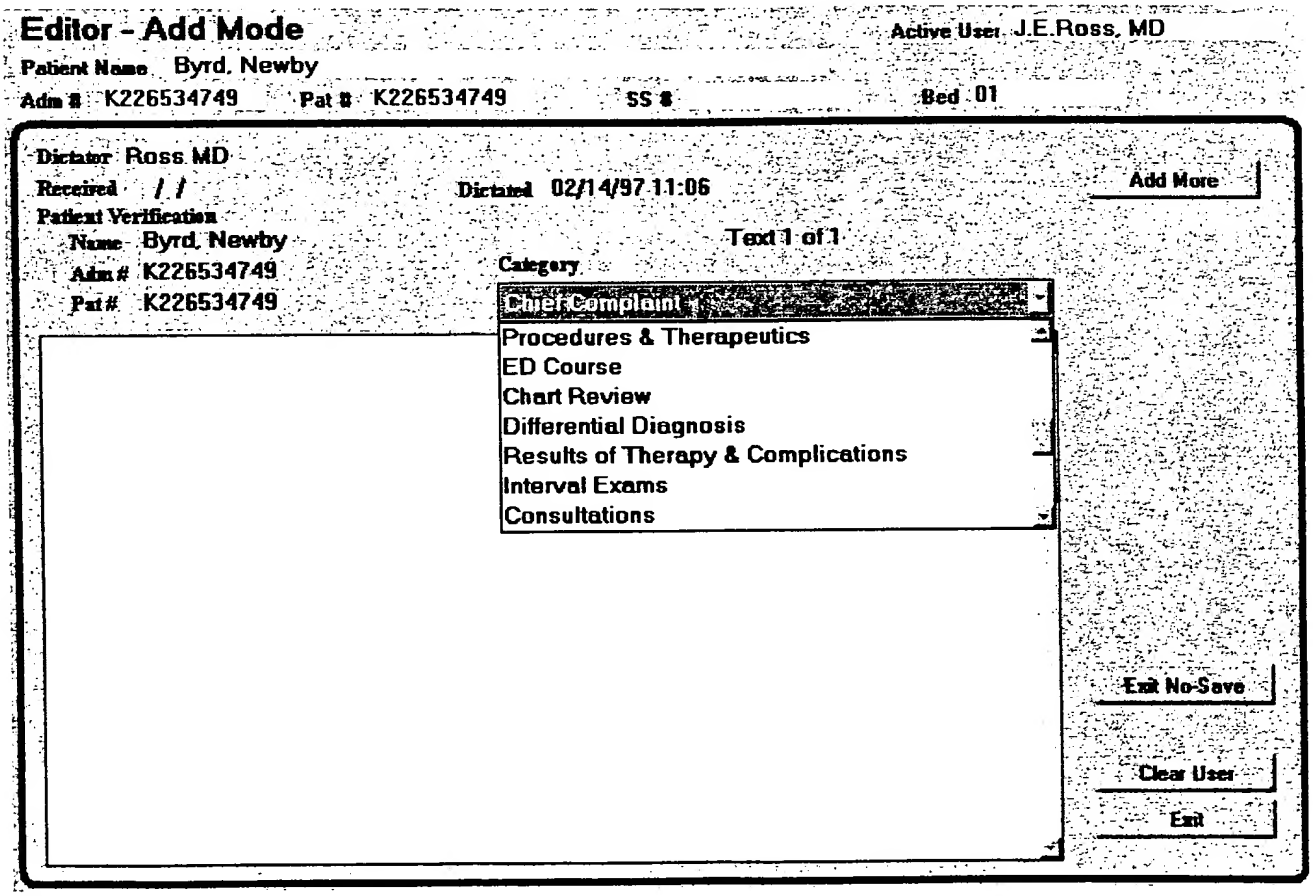
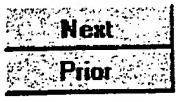


Figure Chapter 3: -69: Differential Diagnosis (in Editor Add Mode)

(Image: editor-add-mode-3.bmp)

Entering/Modifying Differential Diagnosis (manual) *(continued)*



4b. Modify and existing Differential Diagnosis entry:

- Click on Next / Prior (or First / Last) buttons to locate Differential Diagnosis.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

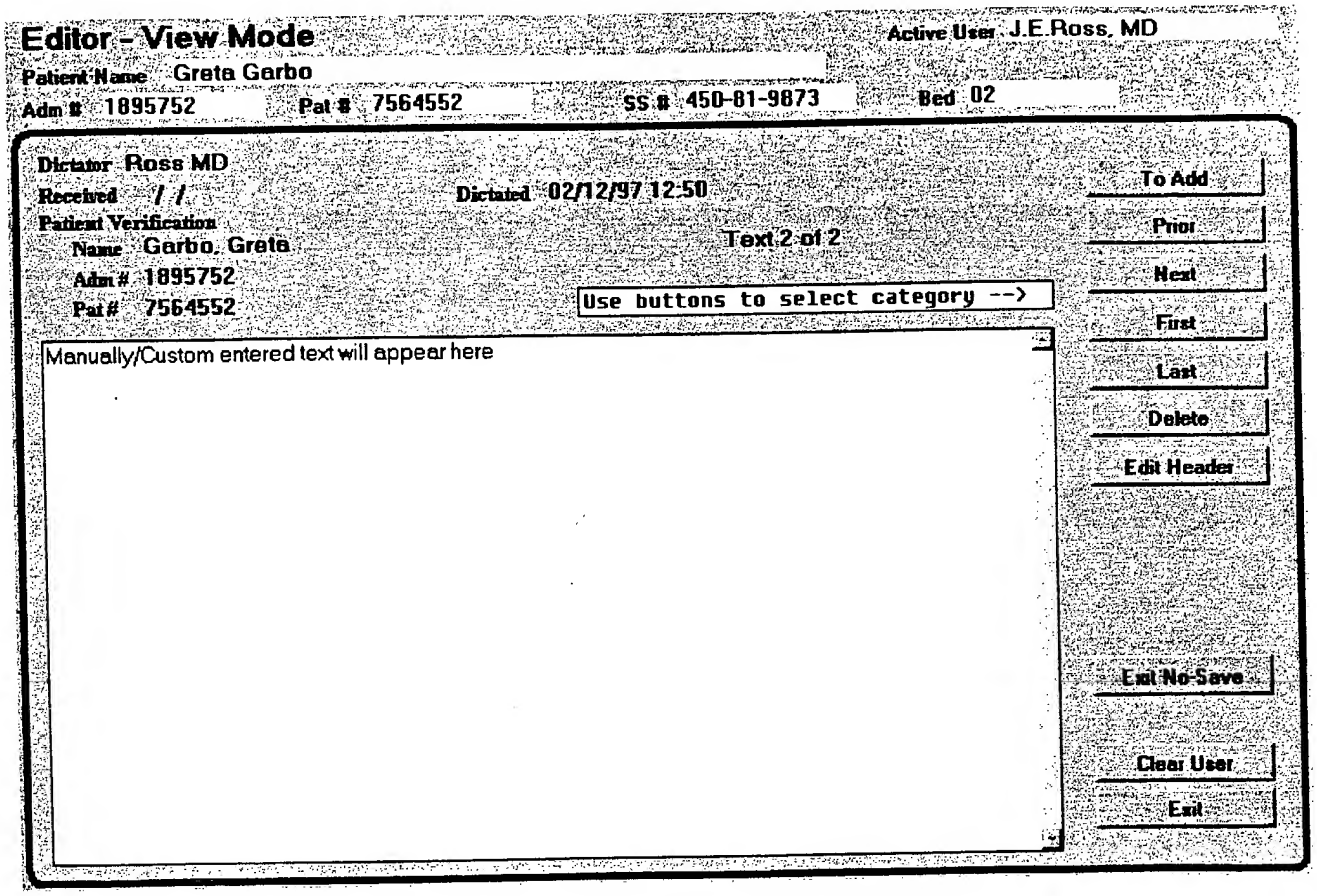


Figure Chapter 3: -70: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

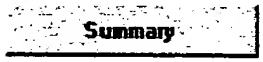
6. Click the Exit button to save updated patient information.

Viewing Differential Diagnosis

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.



3. Click on the Summary button in the HISTORICAL section. [brings you to the Medical Record Summary]

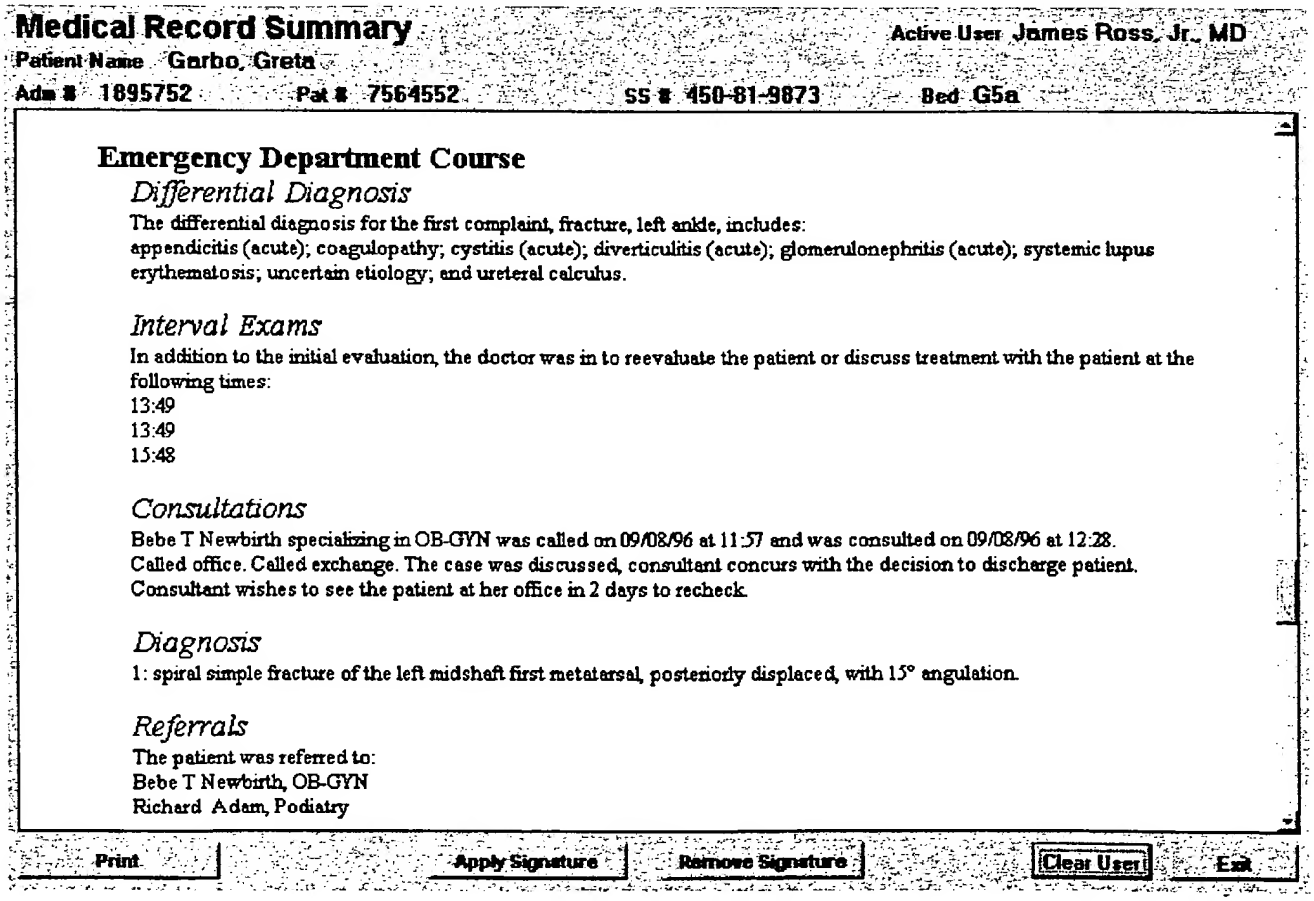


Figure Chapter 3: -71: Medical Record Summary

(Image: medical-record-summary-3.bmp)

4. Click the Scroll Bar to view additional information.

5. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Differential Diagnosis

- The **Prephrased Text** function (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Differential Diagnosis text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.
- ***Alternate access to this screen:***
  Complaint and Final Diagnosis

Multiple & Final Diagnoses

Entering/Modifying Multiple Diagnoses (std. menu)

*From the "Active Patient List" (your main tracking screen)**

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Differential Diagnosis button in the INPUT section.

4a. **If the Complaint section has been completed to a diagnosable level of detail,** the Diagnosis screen will display differential diagnosis.

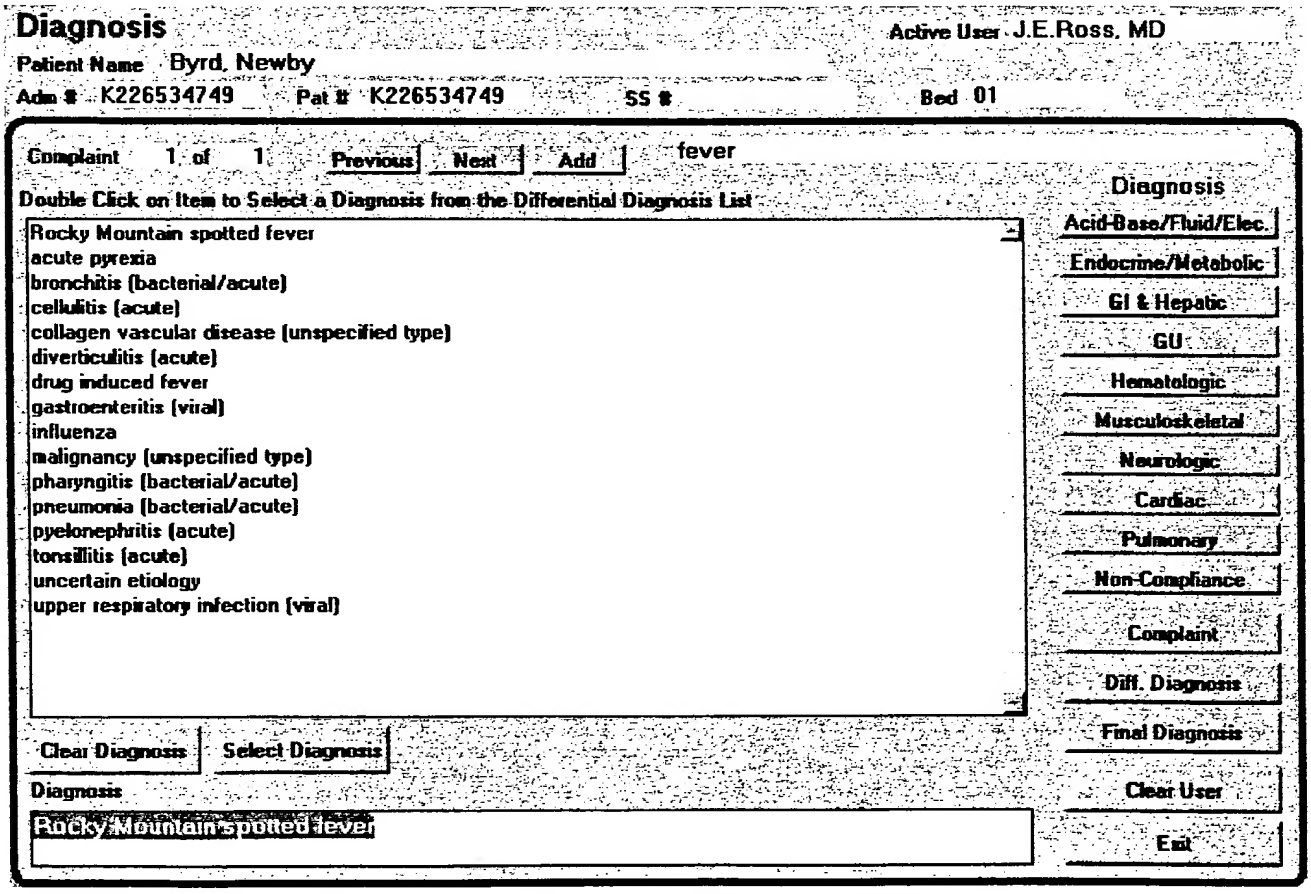
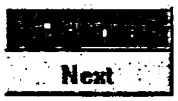


Figure Chapter 3: -72: Diagnosis (with differential diagnosis)

(Image: diagnosis.bmp)



- Select each Complaint (Previous & Next buttons) and enter diagnosis.
- Additional diagnosis groups are provided at the right of screen.

Entering/Modifying Multiple Diagnoses (std. menu) *(continued)*

4b. **If the Complaint section has been partially completed** (i.e. not to a diagnosable level of detail) **or no differential diagnosis exists for the complaint**, the Diagnosis screen will display the appropriate diagnosis screen (Pain, Non-Pain, Trauma, etc)

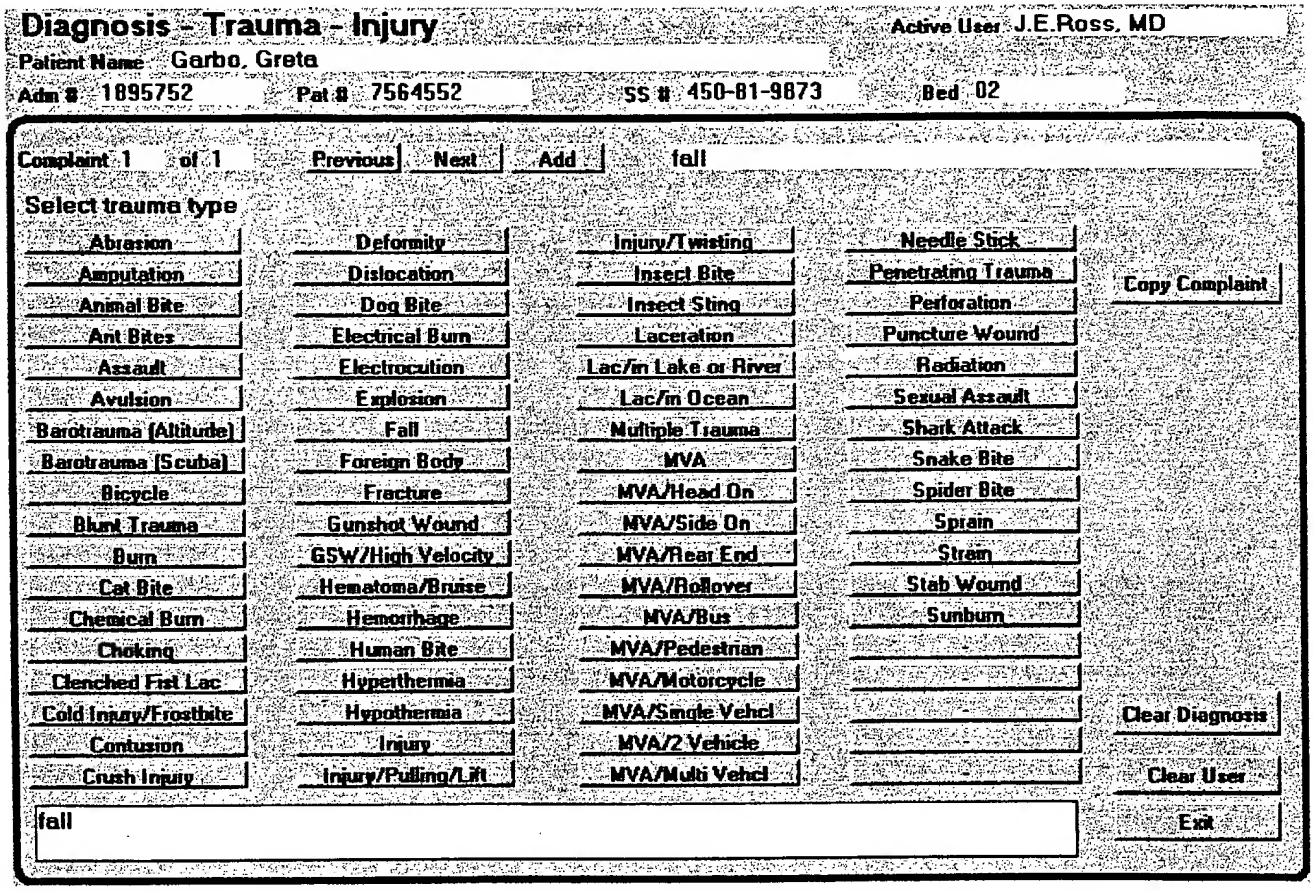


Figure Chapter 3: -73: Diagnosis (for trauma-injury)

(Image: diagnosis-trauma-injury.bmp)

- Select the appropriate diagnosis for each complaint (more than 1 of 1)

Entering/Modifying Multiple Diagnoses (std. menu) *(continued)*

4c. **If no Complaint(s) have been entered,** the Diagnosis screen will display a blank field diagnosis screen.

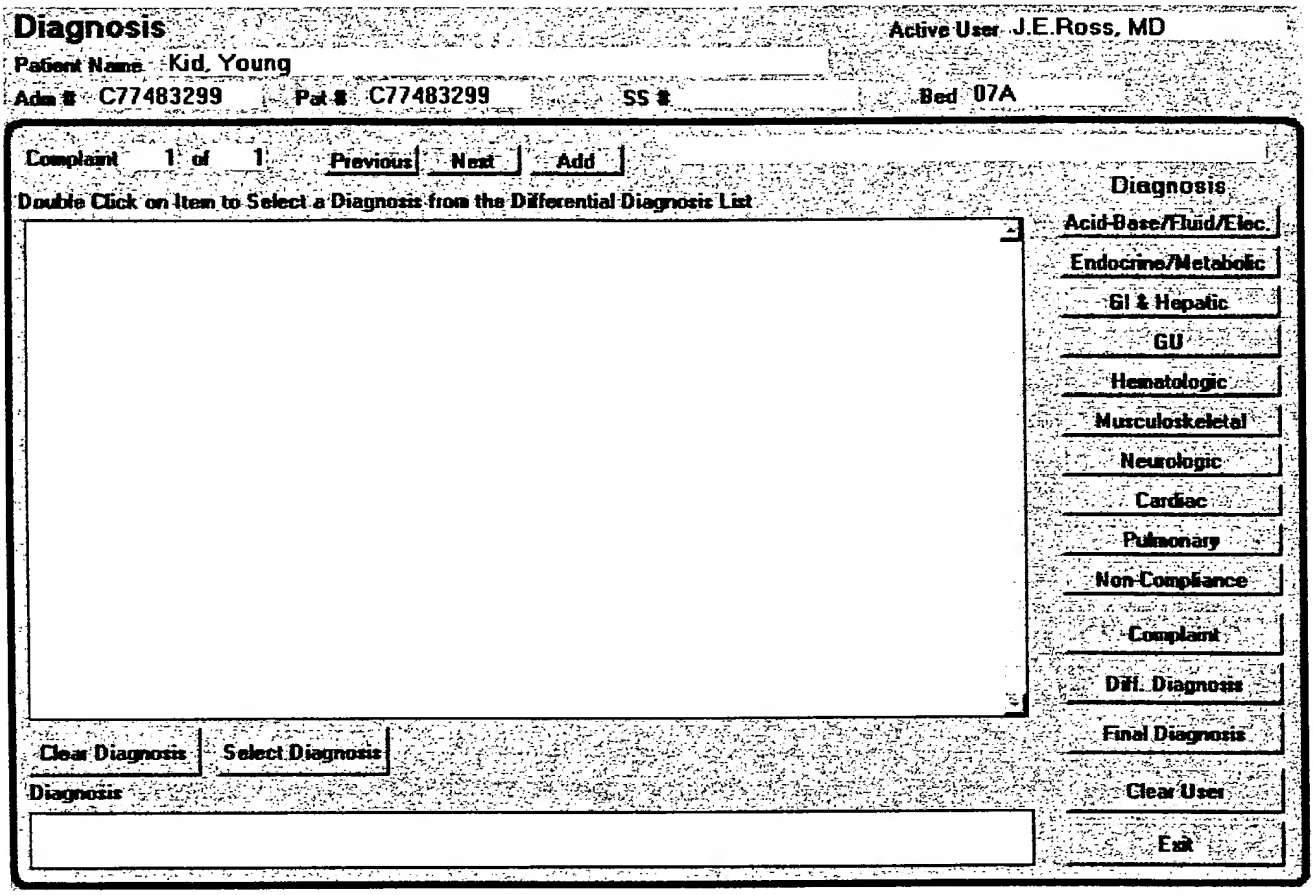
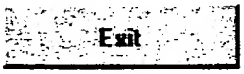


Figure Chapter 3: -74: Diagnosis (no complaint information entered)

(Image: diagnosis-nc.bmp)

- Click on the appropriate Diagnosis button at right of screen to enter menu based diagnosis.



5. Click the Exit button to save updated patient information.

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Entering/Modifying Final/Multiple Diagnosis (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Transcript Editor button in the HISTORICAL section.

4a) Entering a new (Final/Multiple) Diagnosis entry:

- Click on To Add button.
- Open the pull down menu and select "Diagnosis".

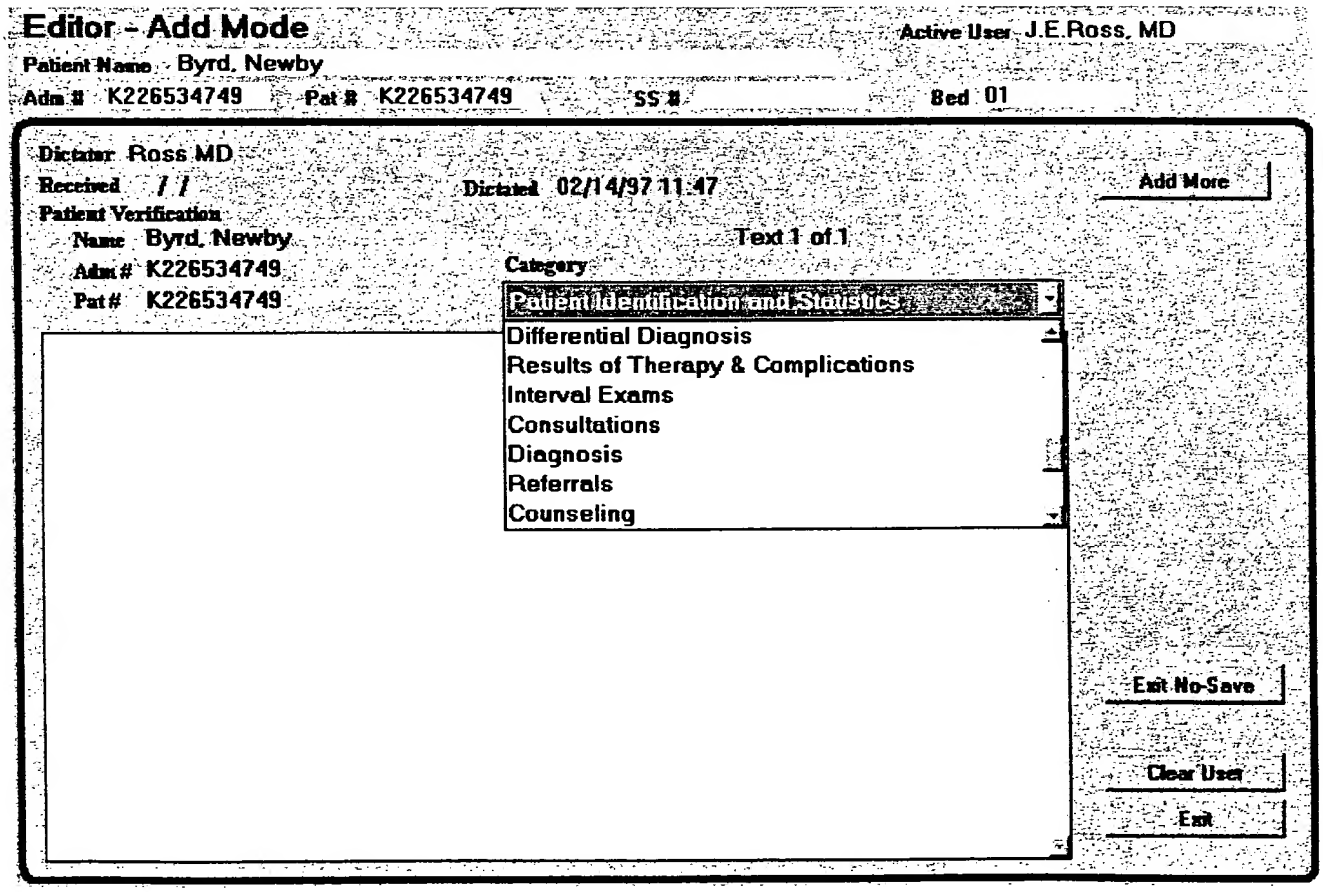
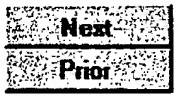


Figure Chapter 3: -75: (Final/Multiple) Diagnosis (in Editor Add Mode)

(Image: editor-add-mode-4.bmp)

Entering/Modifying Final/Multiple Diagnosis (manual) *(continued)*



4b. Modify an existing (Final/Multiple) Diagnosis entry:

- Click on Next / Prior (or First / Last) buttons to locate Diagnosis.
- Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

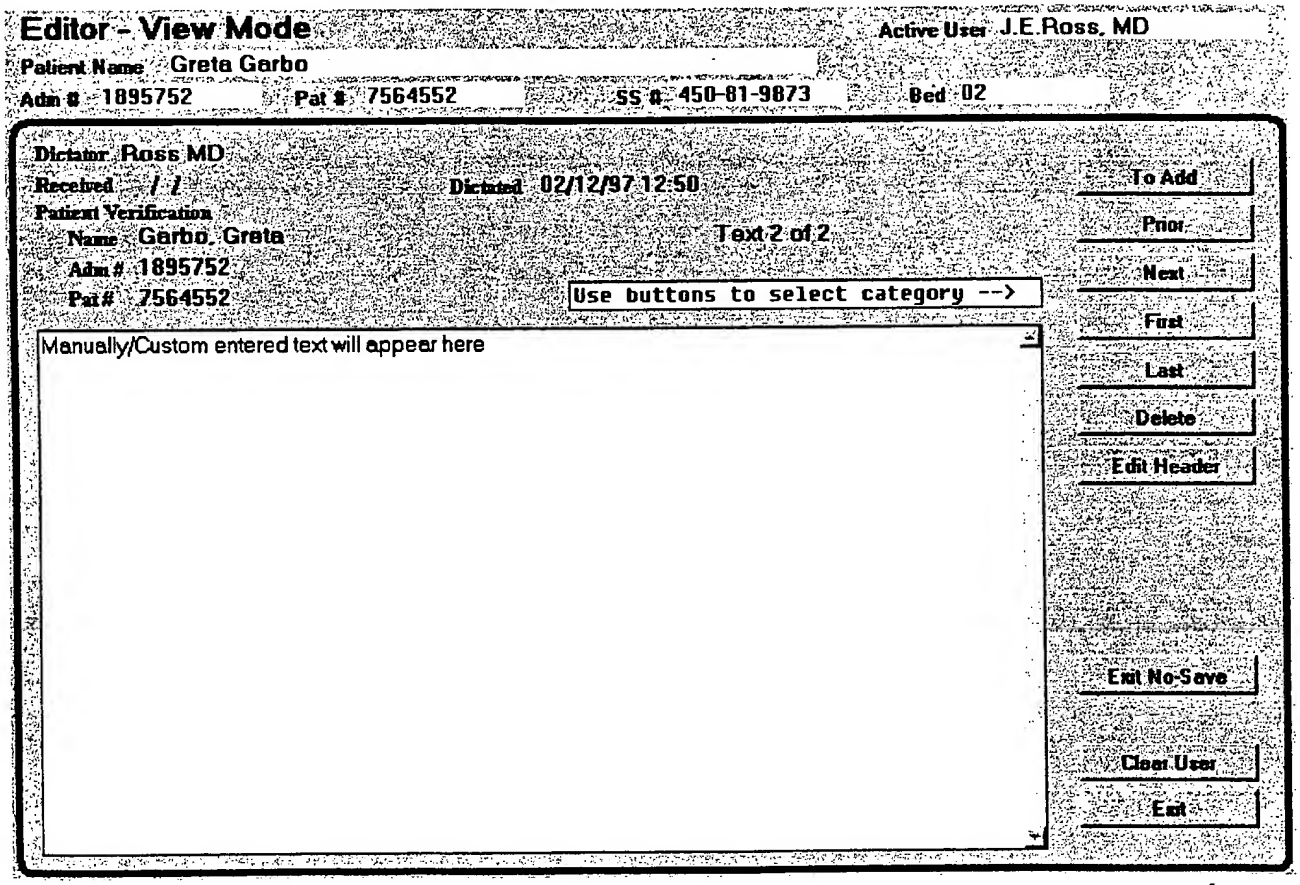
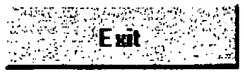


Figure Chapter 3: -76: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)



5. Click the Exit button to save updated patient information.

Viewing Diagnosis

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Summary button in the HISTORICAL section. [brings you to the Medical Record Summary]

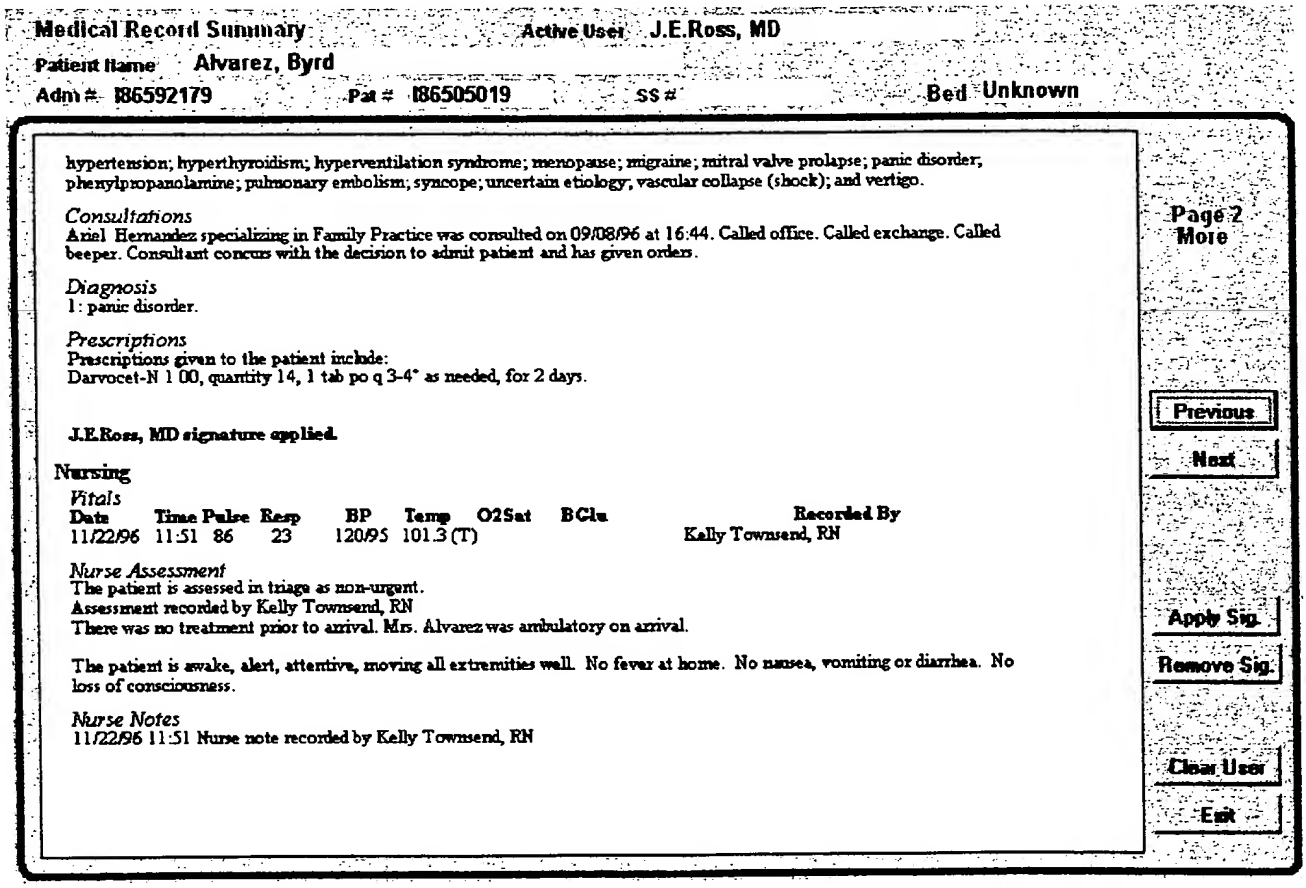
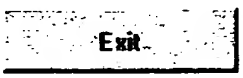


Figure Chapter 3: -77: Medical Record Summary

(Image: medical-record-summary-3.bmp)

4. Click the Scroll Bar to view additional information.



5. Click the Exit button to return to the Medical Information screen.

Final Diagnoses

Entering/Modifying Final Diagnoses (std. menu)

*From the "Active Patient List" (your main tracking screen)**

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3a. Click on the Complaint button in the INPUT section.

Or

3b. Click on the Differential Diagnosis button in the INPUT section.

4. Click on the Final Diagnosis button.

5. Add and Clear Diagnosis as required. The diagnosis screen options & format will be the same as described on page 126, "Entering/Modifying Multiple Diagnoses (std. menu)".

6. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Multiple & Final Diagnosis

- The **Prephrased Text** function (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based (Final/Multiple) Diagnosis text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.

- ***Alternate access to this screen:***
  Complaint and Differential Diagnosis

Lab Requests & Results

Requesting Labs (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Lab Requests button in the INPUT section.
   - This opens the "Labs Ordered - General" screen. For more specific labs, click on the appropriate buttons under "Other Labs" on the right side of the screen.
4. Request each lab needed via the lab screen's check box menu. Complete any editable form fields as required.

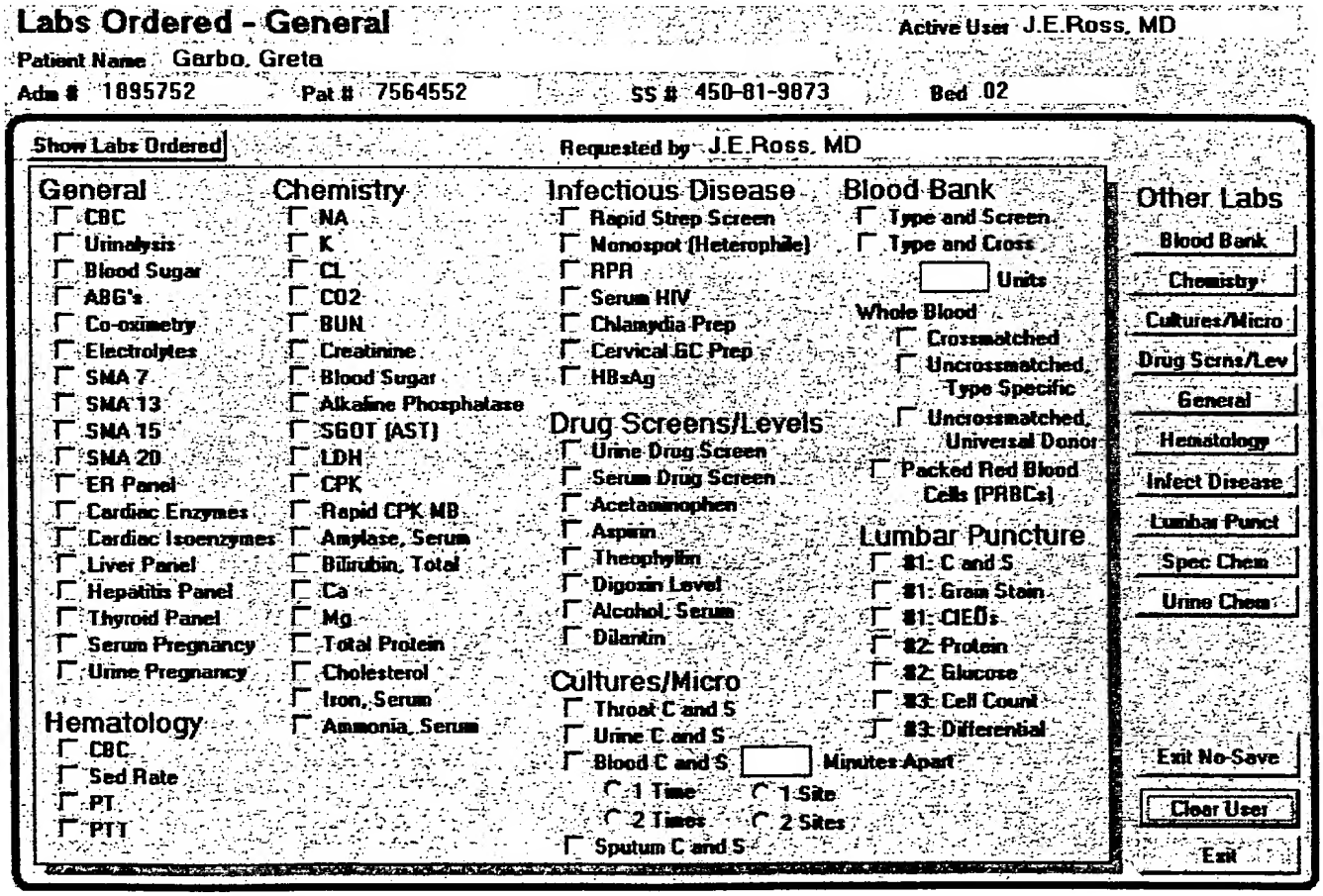
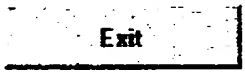


Figure Chapter 3: -78: Labs Ordered- General
(Image: labs-ordered.bmp)



5. Click the Exit button to return to the Medical Information screen.

Viewing Labs Requested

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Lab Requests button in the INPUT section.

4. Click on the Show Labs Ordered button.

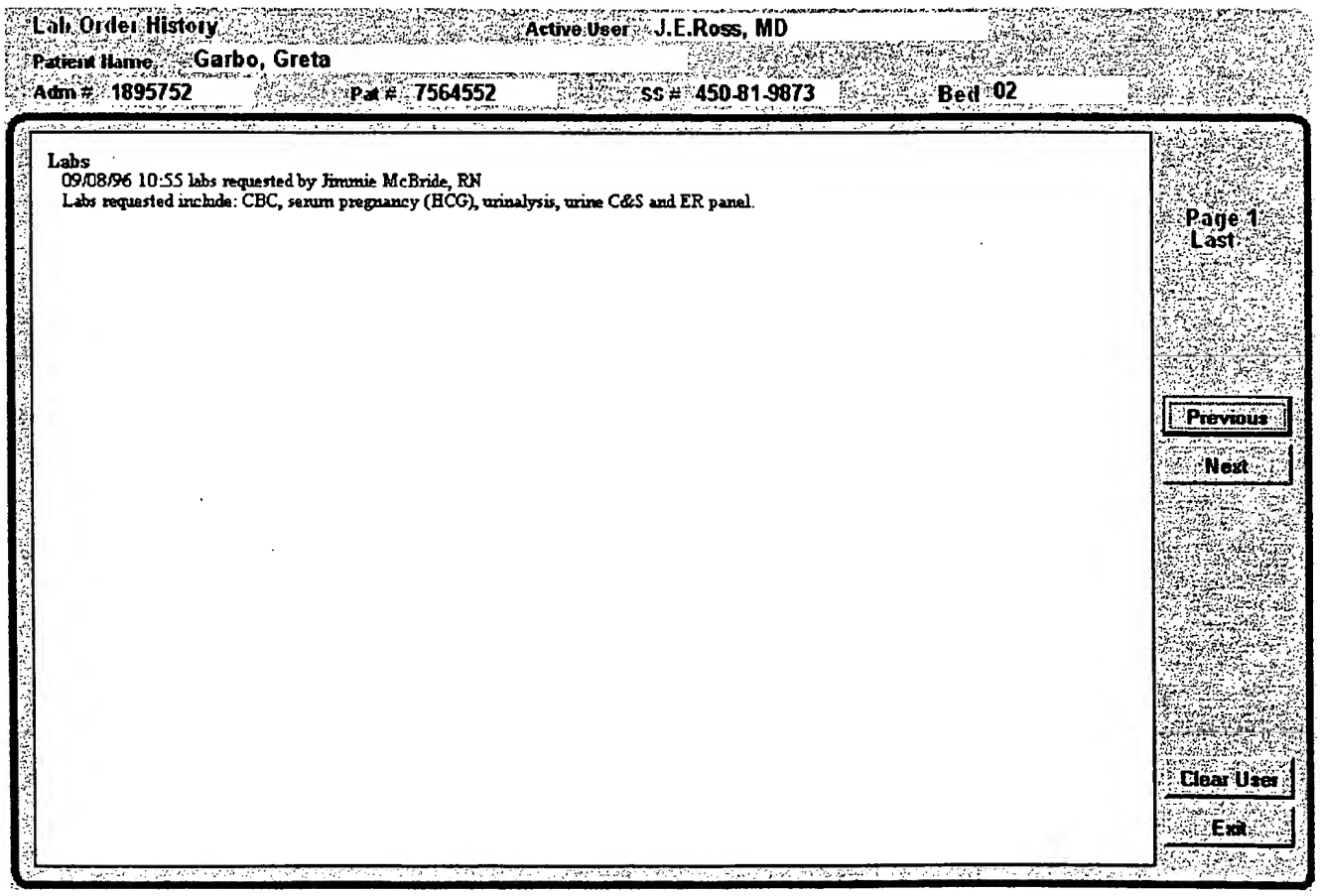


Figure Chapter 3: -79: Lab Order History

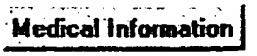
(Image: lab-order-history.bmp)

5. Click the Exit button to return to the Medical Information screen.

Entering/Updating Lab Results (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).



2. Click the Medical Information button.

3. Click on the Lab Results button in the HISTORICAL section.

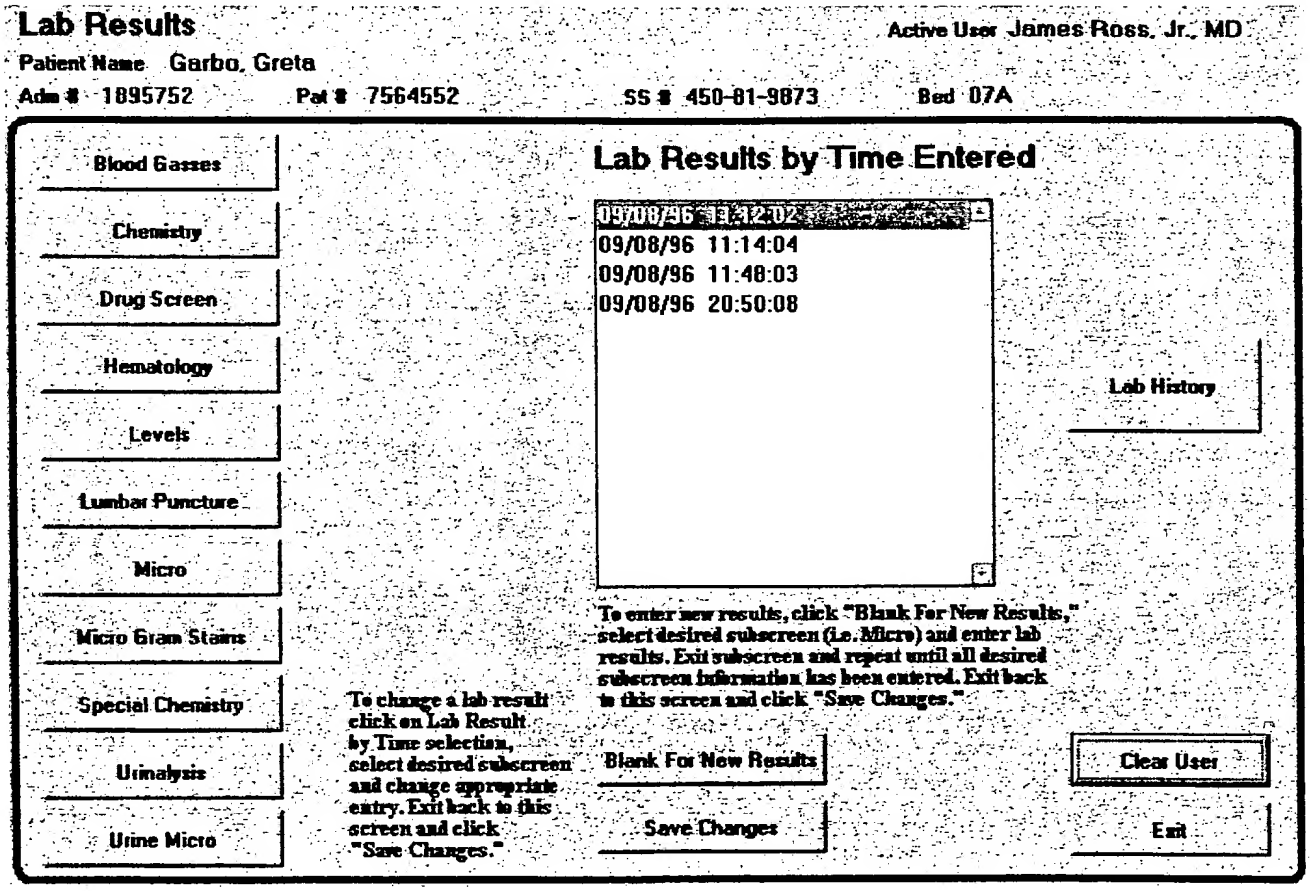


Figure Chapter 3: -80: Lab Results (menu)

(Image: lab-results.bmp)

4a. To enter new results

- Click the "Blank for New Results" button.
- Select desired lab category (Ex. Blood Gases, next page).
- Enter results.

Entering/Updating Lab Results (std. menu) *(continued)*

4b. To update results:

- Select desired lab category (Ex. Blood Gases).
- Click on check boxes and form fields to complete as appropriate.

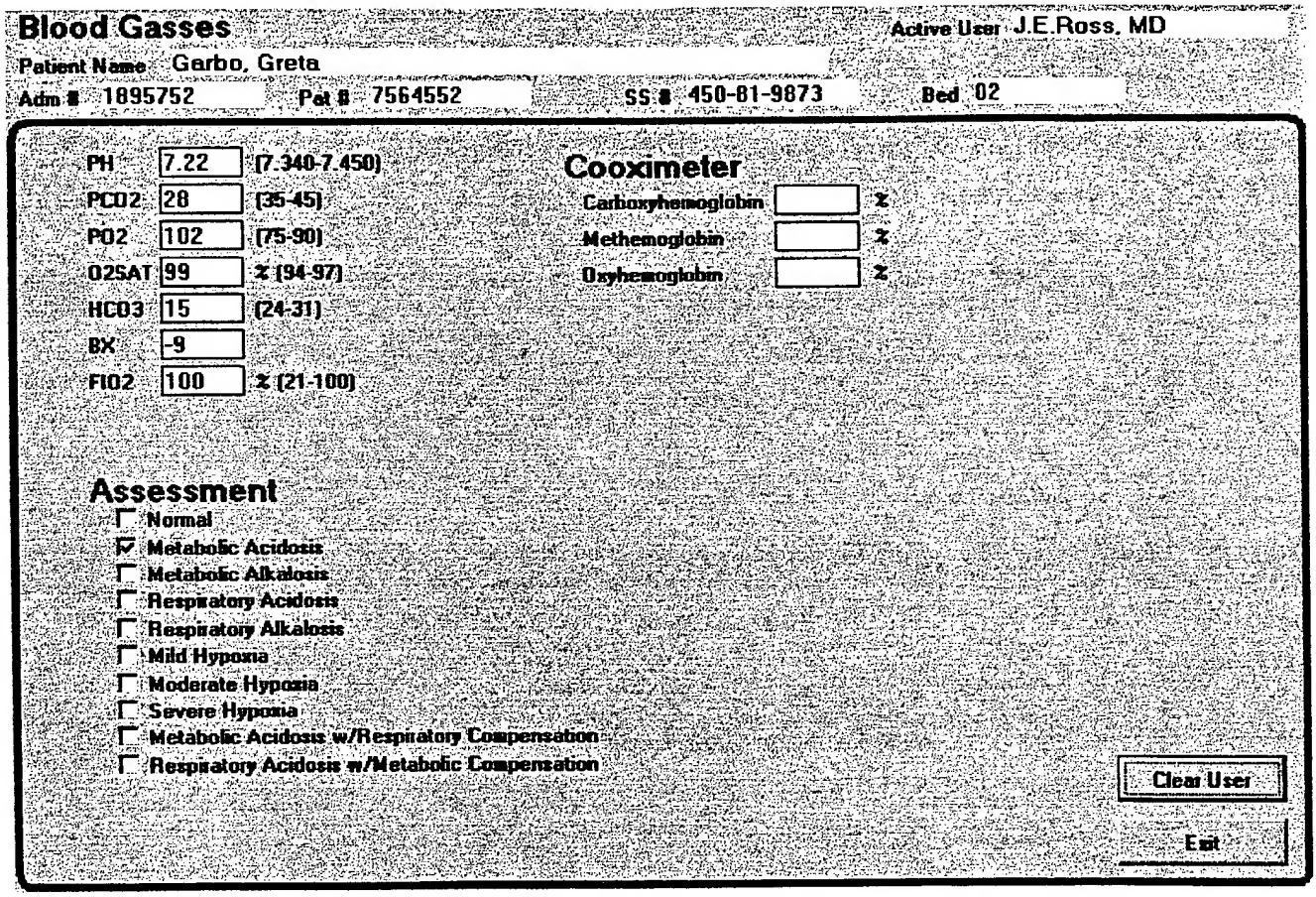


Figure Chapter 3: -81: Blood Gases

(Image: blood-gases.bmp)

5. Click the Exit button to save Lab Results.

Entering/Updating Lab Comments in the Medical Record (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Transcript Editor button in the HISTORICAL section.

4a) Entering a new Labs comment entry:

- Click on To Add button.
- Open the pull down menu and select "Labs".

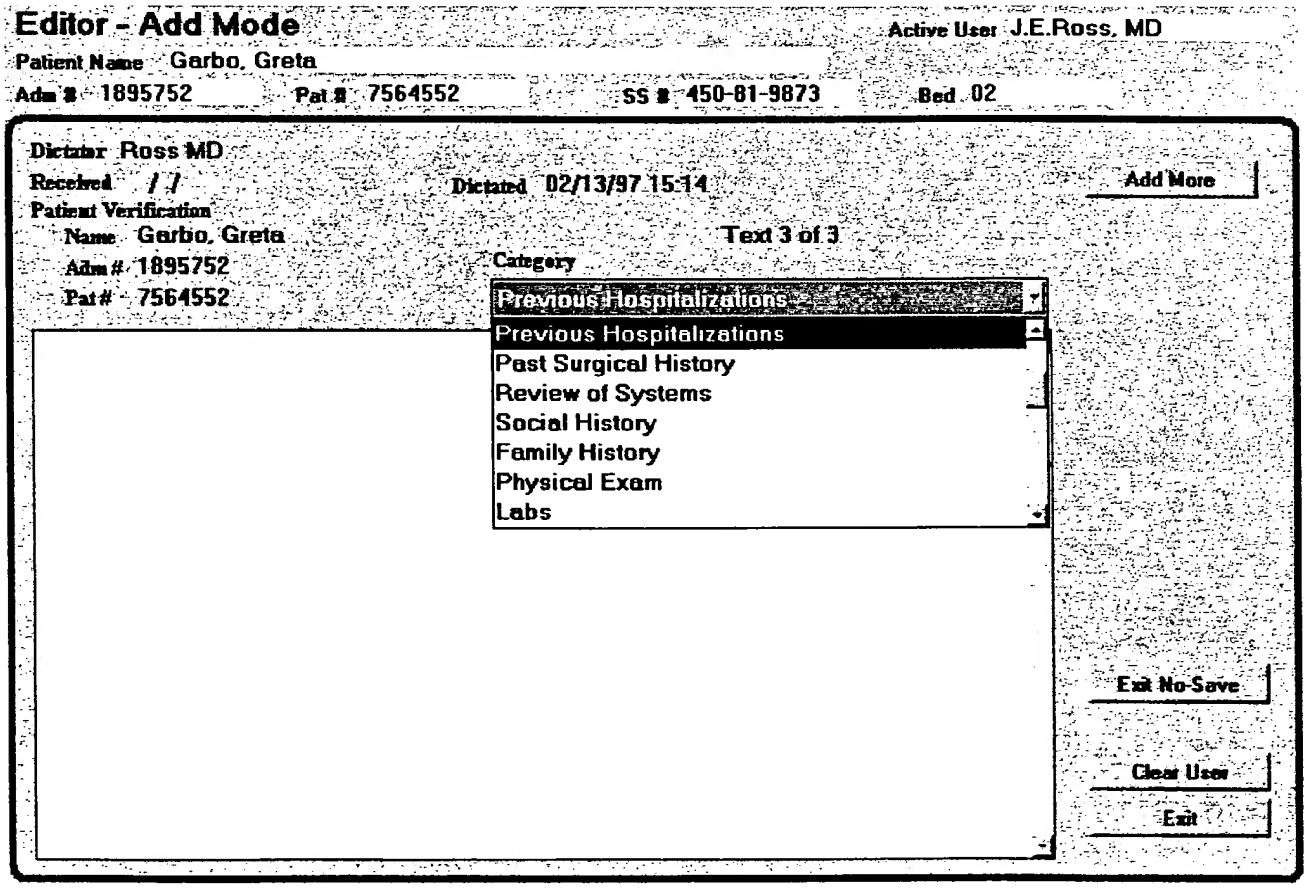
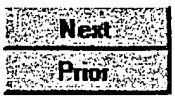


Figure Chapter 3: -82: Labs (in Editor Add Mode)

(Image: editor-add-mode-2.bmp)

Entering/Modifying Lab Comments (manual) *(continued)*



4b. Modify an existing Lab comment entry:

- Click on Next / Prior (or First / Last) buttons to locate Labs.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

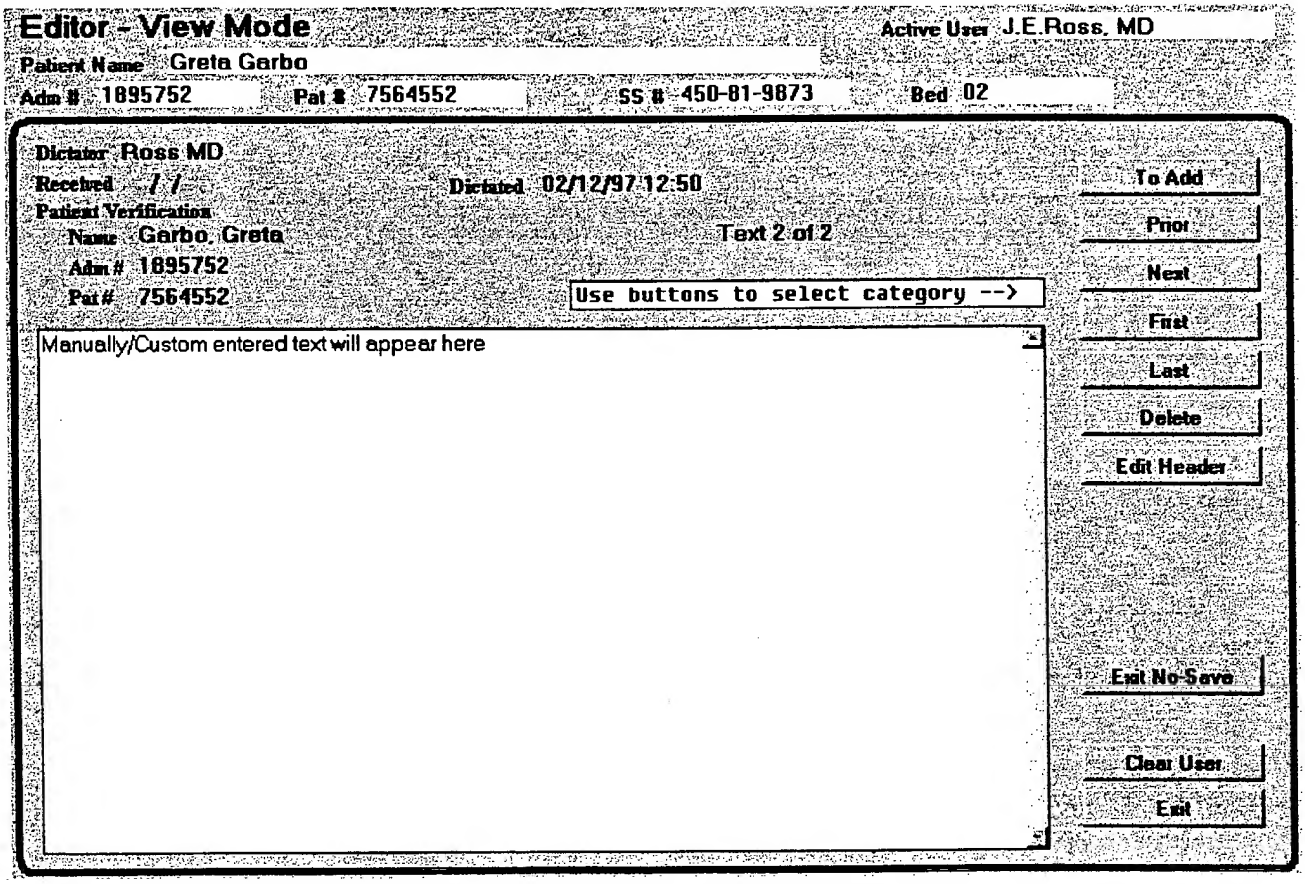


Figure Chapter 3: -83: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

6. Click the Exit button to save updated patient information.

Viewing Lab Results

→ Option A

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Lab Results button in the HISTORICAL section.

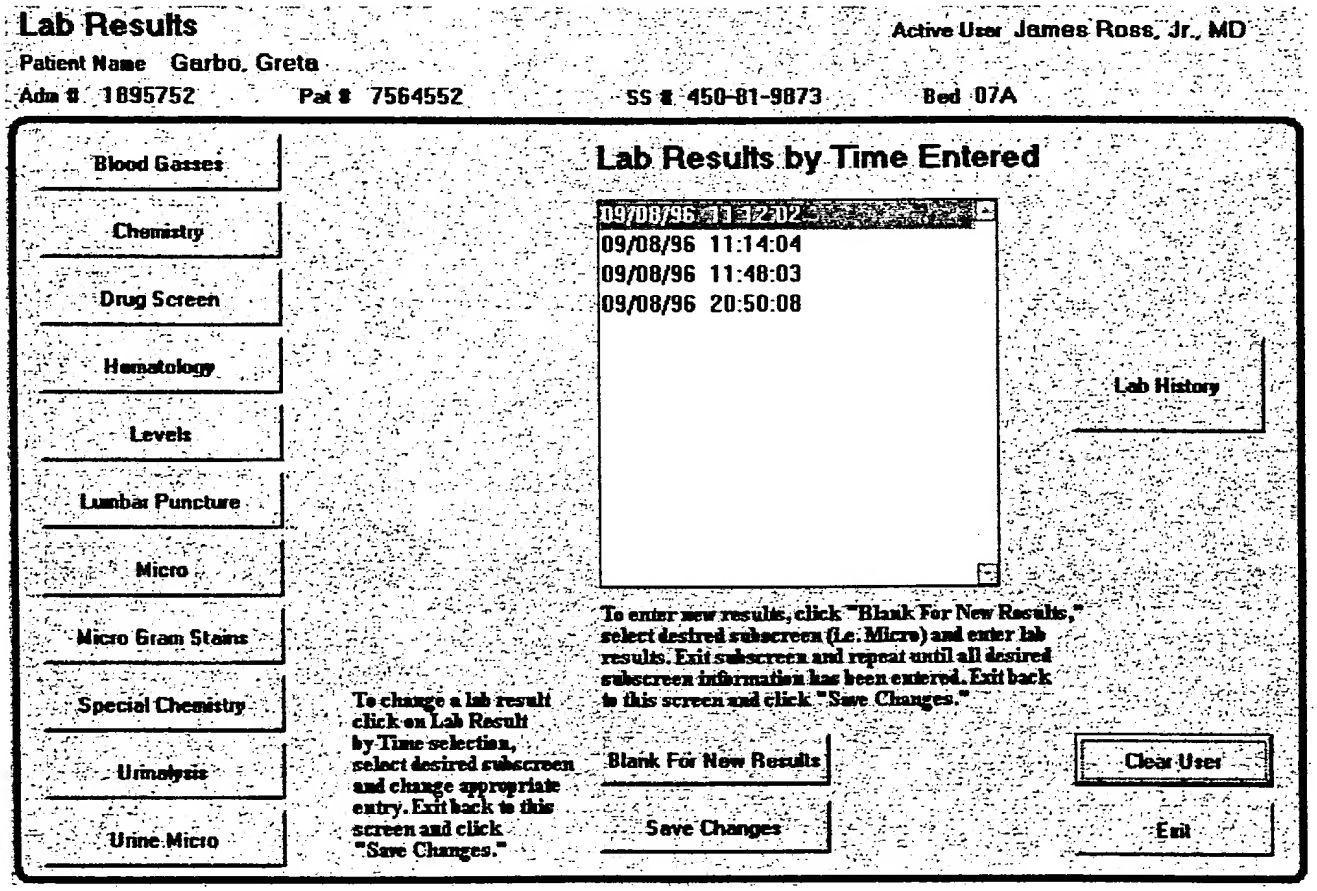
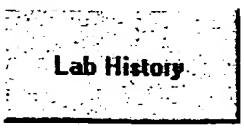


Figure Chapter 3: -84: Lab Results (menu)

(Image: lab-results.bmp)



4. Click the Lab History button to see all results up to the latest.
   - If you wish to examine an older set of results, double-click the appropriate date/time entry and then click the Overview button.

Viewing Lab Results

→ **Option A (continued)**

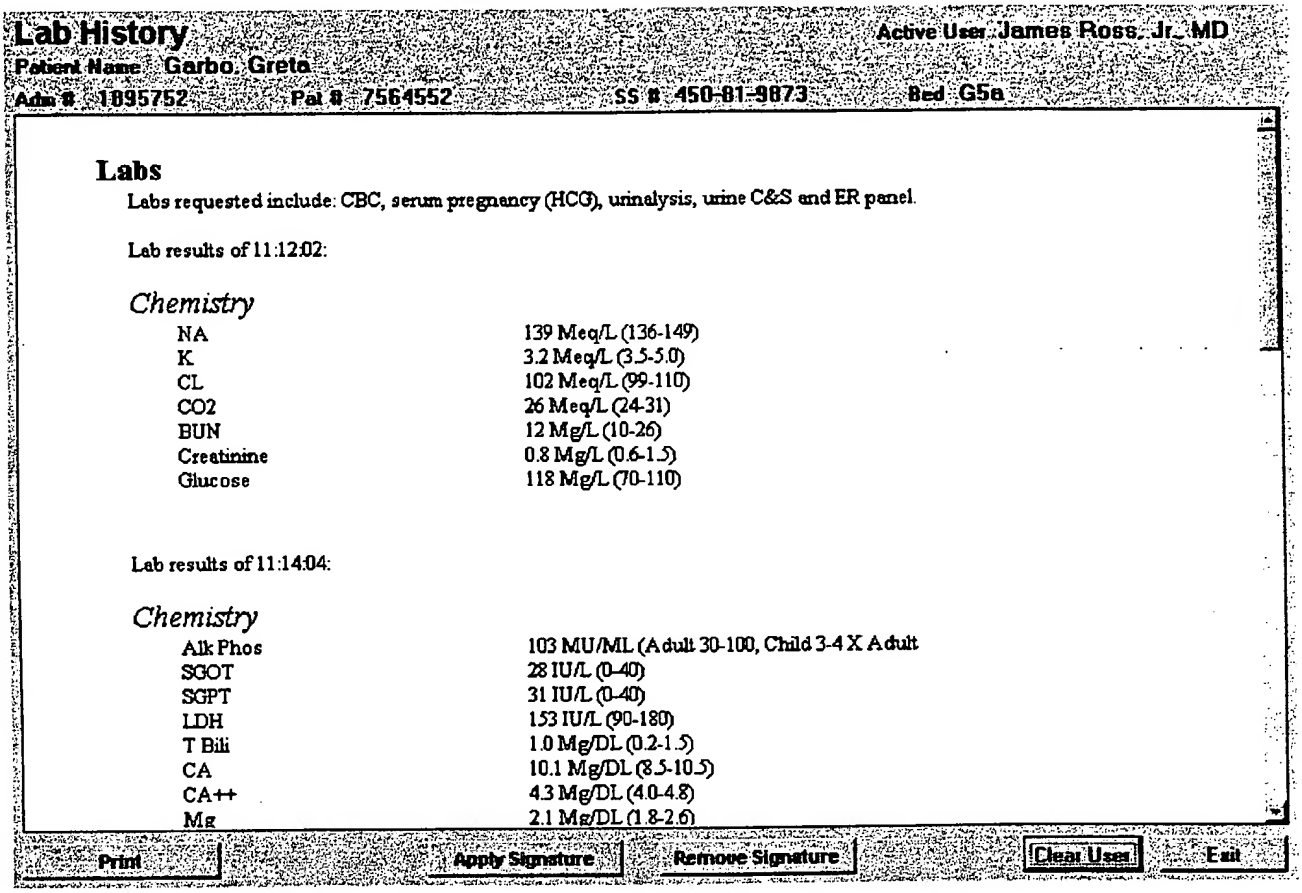


Figure Chapter 3: -85: Lab (results) Overview

(Image: lab-history.bmp)

5. Click the Exit button (twice) to return to the Medical Information screen.

Viewing Lab Results *(continued)*

→ Option B

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Summary button in the HISTORICAL section. [brings you to the Medical Record Summary]

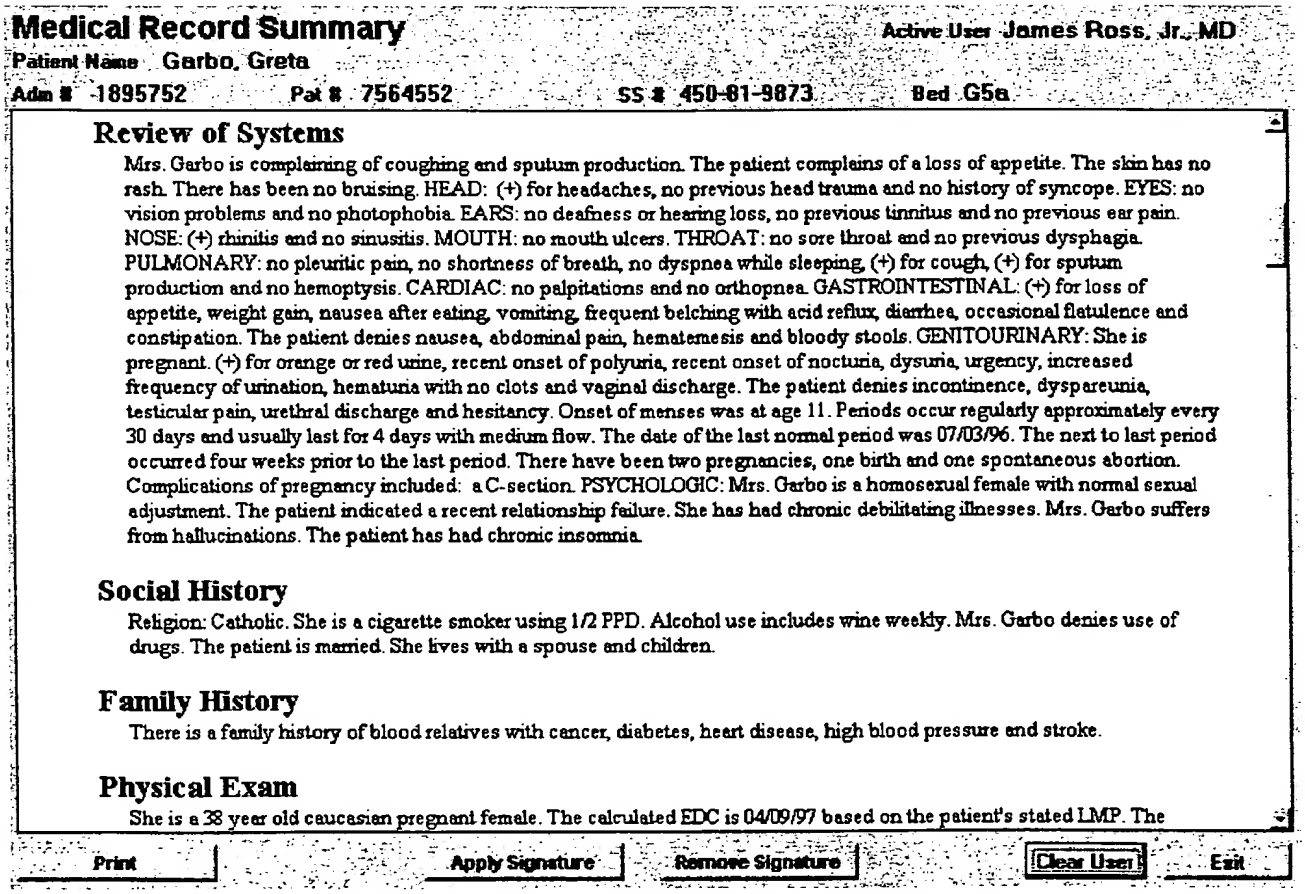
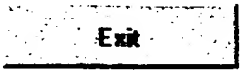


Figure Chapter 3: -86: Medical Record Summary

(Image: medical-record-summary-b.bmp)

4. Click the Scroll Bar to view additional information.



5. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Lab Requests and Results

- The **Prephrased Text** function (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Lab (comments, not requests) text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.

- ***Alternate access to this screen***
  Tests & X-Rays screens

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X-Ray Requests

Requesting X-Rays (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Radiology Requests button in the INPUT section.

4. Select the appropriate X-Ray input screen: General (default), Extremities or Other.

5. Select the appropriate X-Ray location from the screen's check box menu.

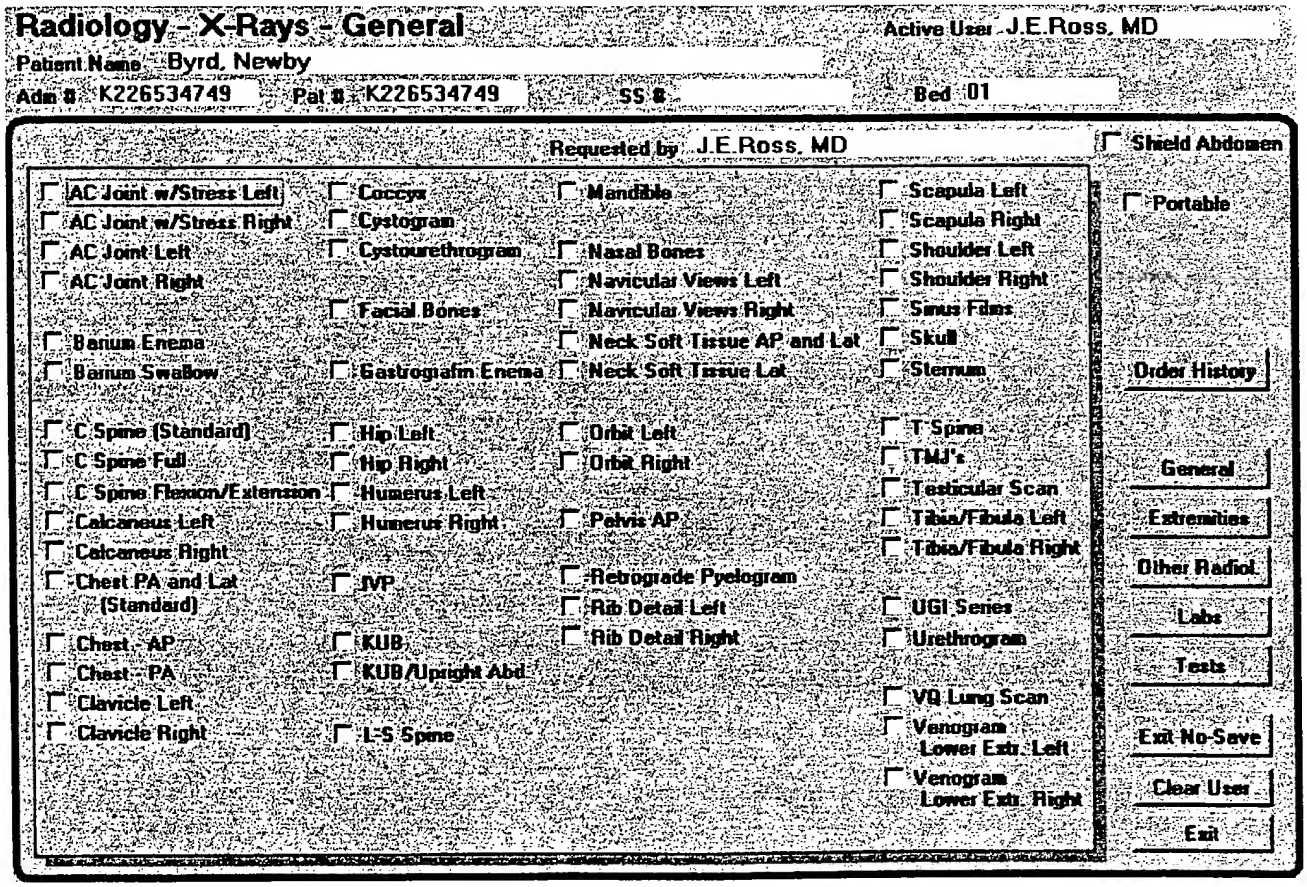


Figure Chapter 3: -87: Radiology-X-Ray-General
(Image: radiology-xrays-general.bmp)

6. Click the Exit button to save updated patient information.

Updating X-Ray Comments (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Transcript Editor button in the HISTORICAL section.

4a) Entering a new X-Rays comment entry:

- Click on To Add button.
- Open the pull down menu and select "X-Rays".

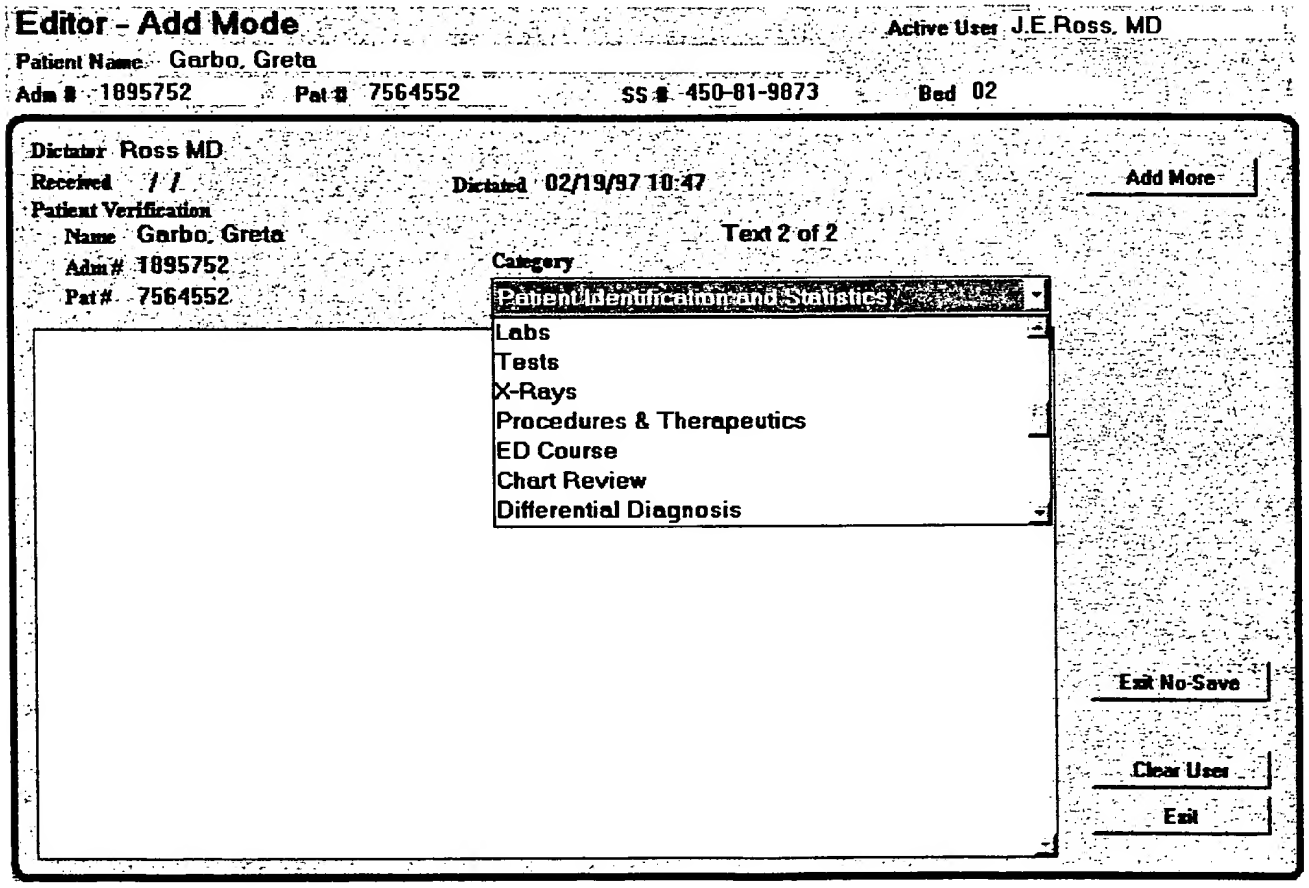


Figure Chapter 3: -88: X-Rays (in Editor Add Mode)

(Image: editor-add-mode-5.bmp)

Entering/Modifying X-Ray Comments (manual) *(continued)*

4b. Modify an existing X-Ray comment entry:

- Click on Next / Prior (or First / Last) buttons to locate X-Rays.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

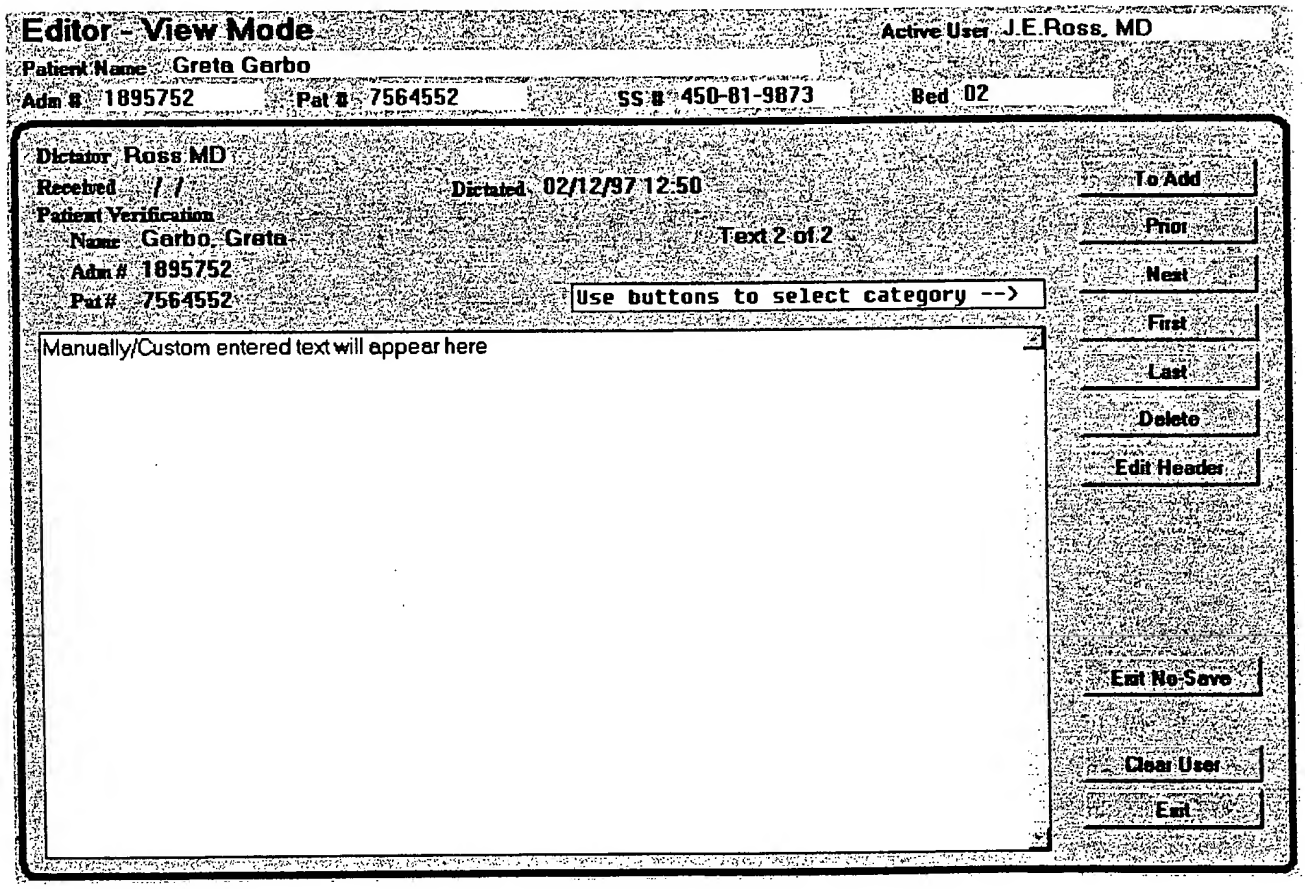


Figure Chapter 3: -89: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

6. Click the Exit button to save updated patient information.

Viewing X-Ray Requests

→ Option A

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Radiology Requests button in the INPUT section.

4. Click on the Order History button.

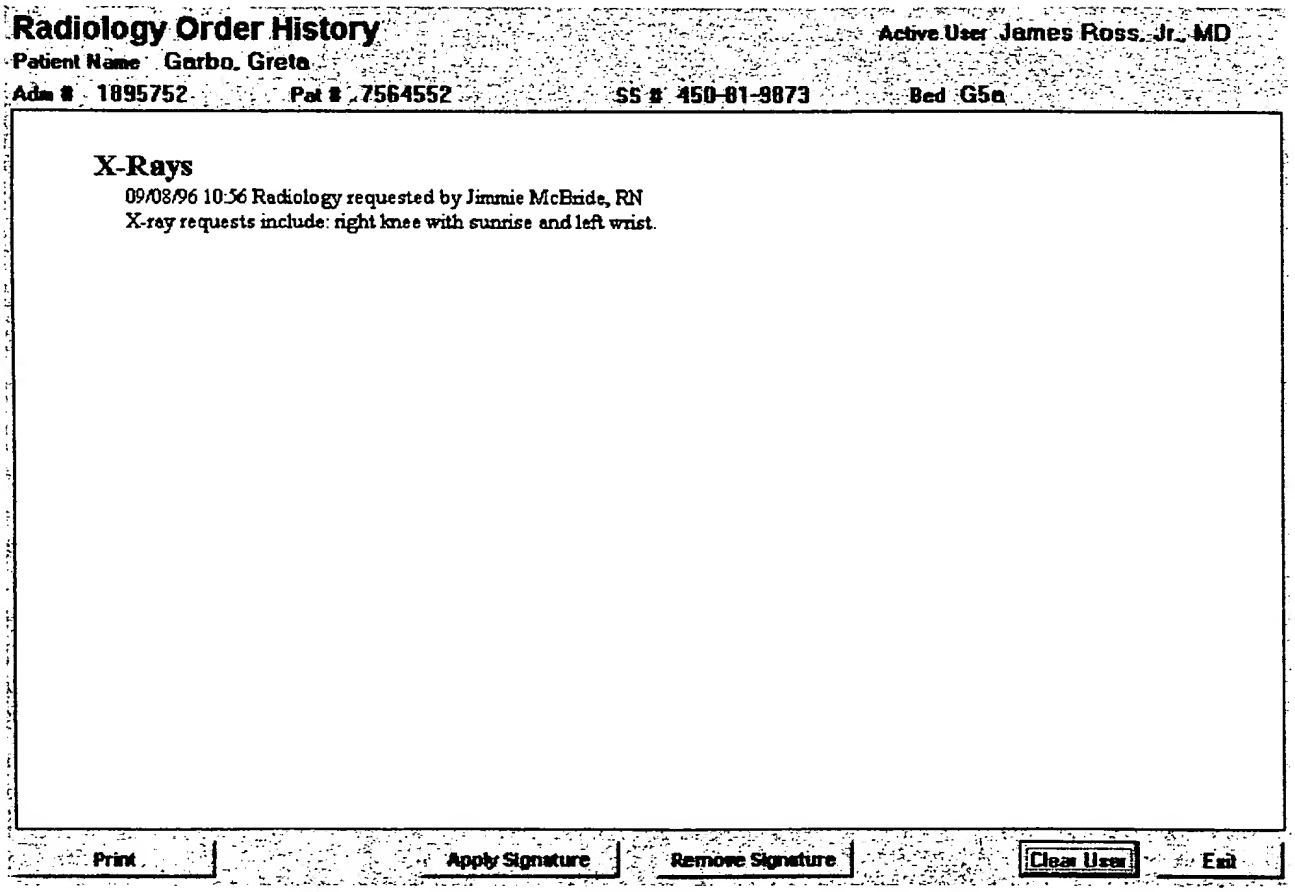


Figure Chapter 3: -90: X-Ray Order History

(Image: rad-order-history.bmp)

5. Click the Exit button (twice) to return to the Medical Information screen.

Viewing X-Ray Requests *(continued)*

→ **Option B**

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Summary button in the HISTORICAL section. [brings you to the Medical Record Summary]

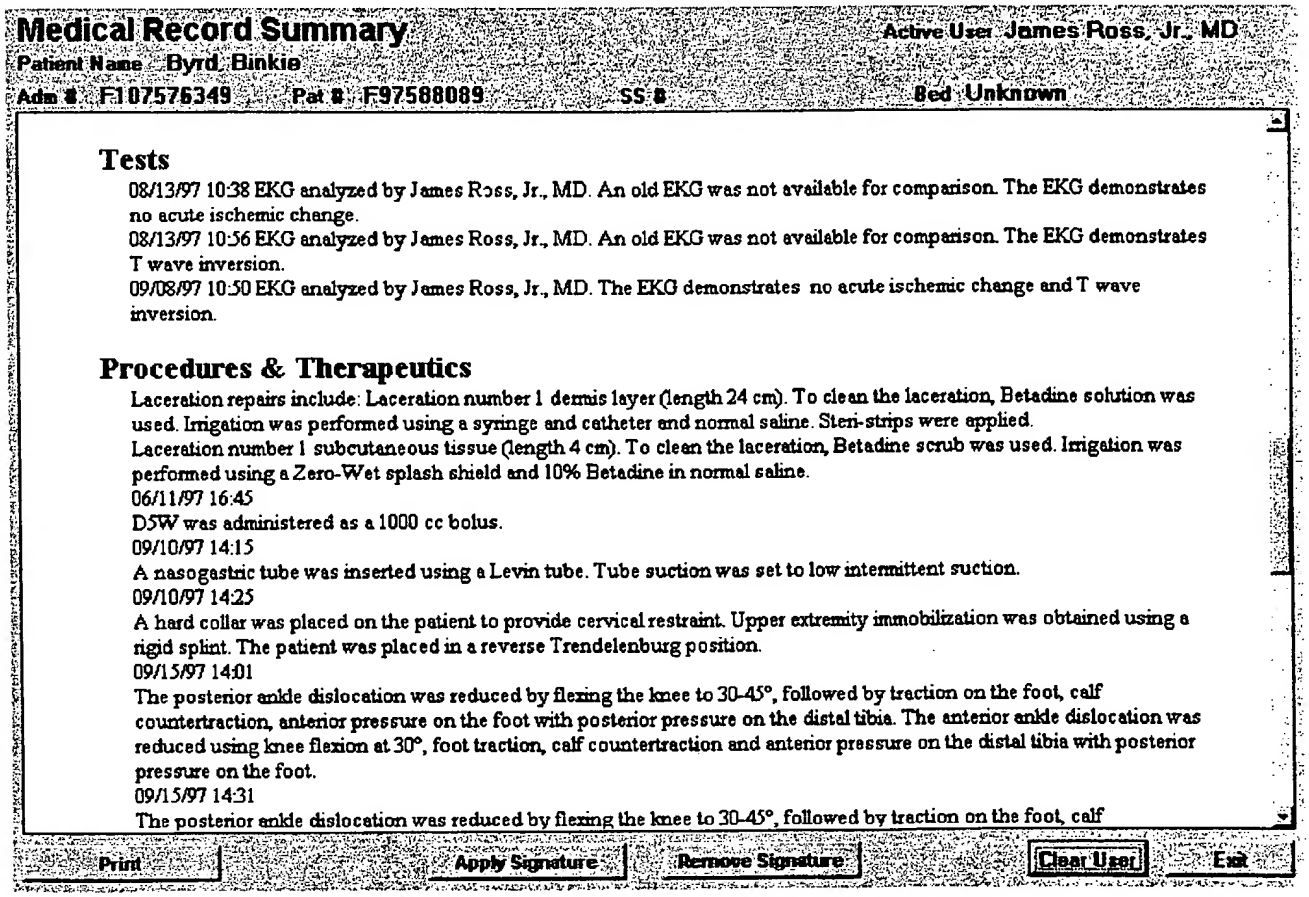


Figure Chapter 3: -91: Medical Record Summary

(Image: medical-record-summary-c.bmp)

4. Click the Scroll Bar to view additional information.

5. Click the Exit button to return to the Medical Information screen.

Tips and Hints: X-Ray Requests

- The **Prephrased Text** function (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based X-Ray Requests (comments, not requests) text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.

- ***Alternate access to this screen***
  Tests screen

Test Requests

Requesting Tests (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Test Requests button in the INPUT section.

4. Select the appropriate Test from the screen's check box menu.

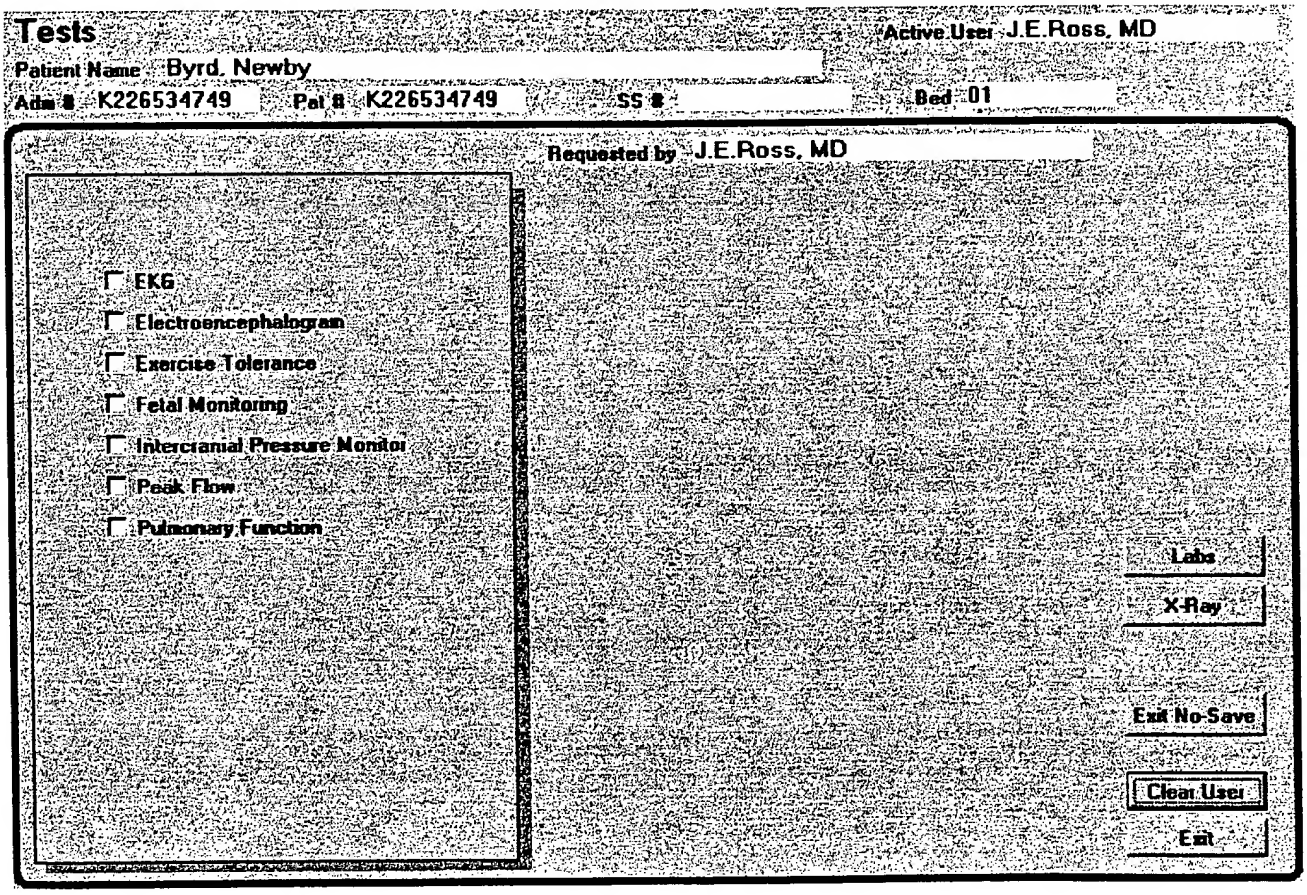


Figure Chapter 3: -92: Tests

(Image: tests.bmp)

5. Click the Exit button to save updated patient information.

Updating Test Requests (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Transcript Editor button in the HISTORICAL section.

4a) Entering a new Tests comment entry:

- Click on To Add button.
- Open the pull down menu and select "Tests".

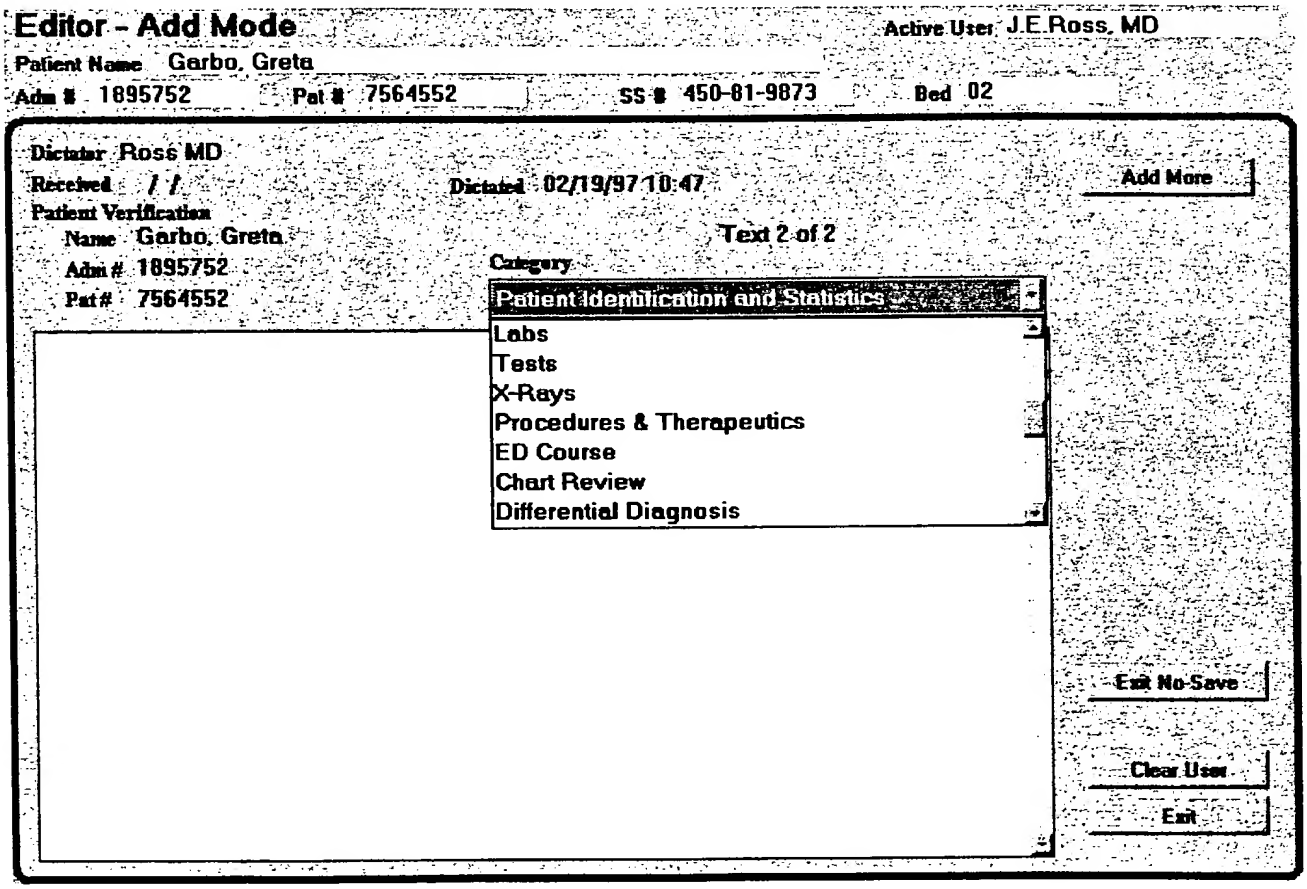


Figure Chapter 3: -93: Tests (in Editor Add Mode)

(Image: editor-add-mode-5.bmp)

Entering/Modifying Test Comments (manual) *(continued)*

4b. Modify an existing Tests comment entry:

- Click on Next / Prior (or First / Last) buttons to locate Tests.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

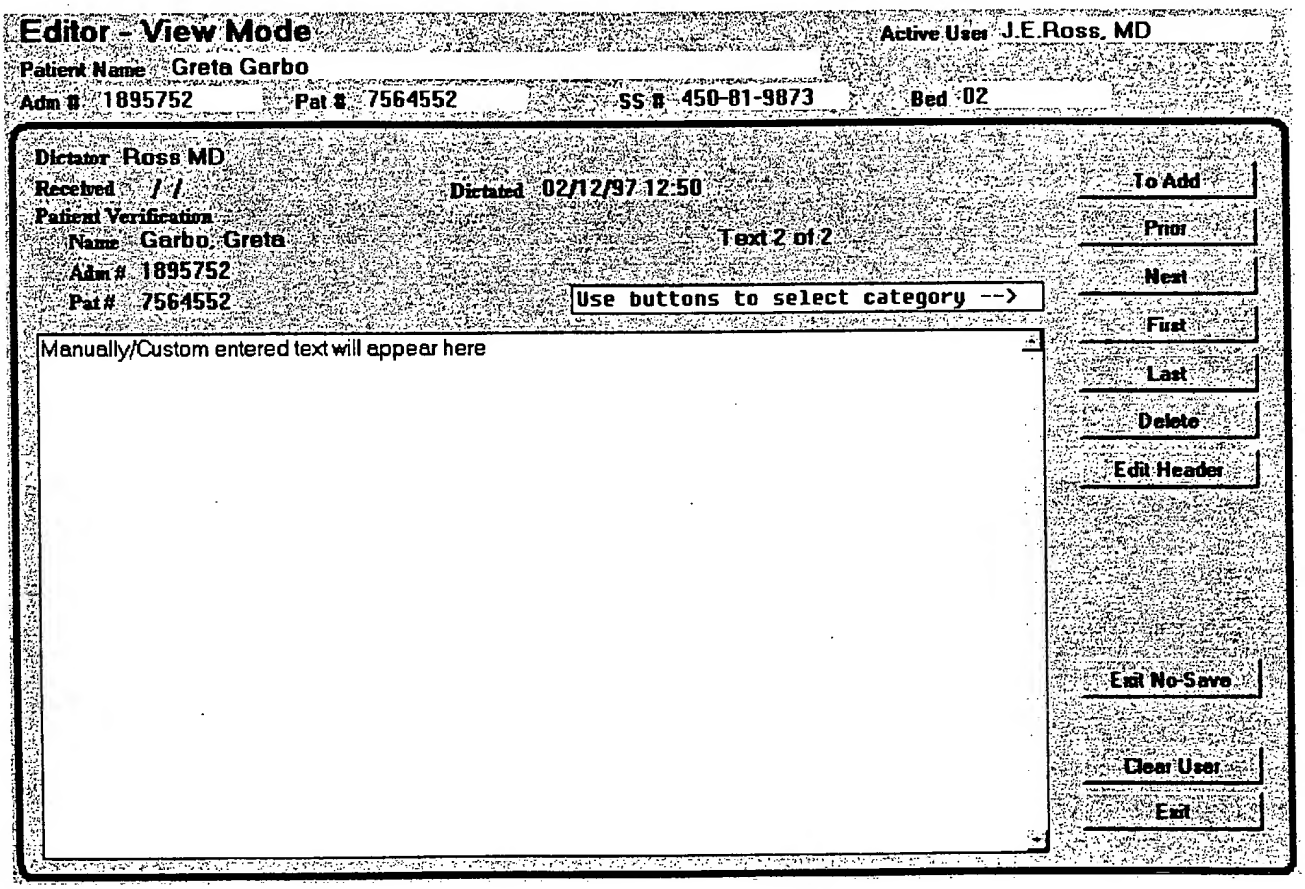


Figure Chapter 3: -94: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

6. Click the Exit button to save updated patient information.

Viewing Test Requests

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Summary button in the HISTORICAL section. [brings you to the Medical Record Summary]

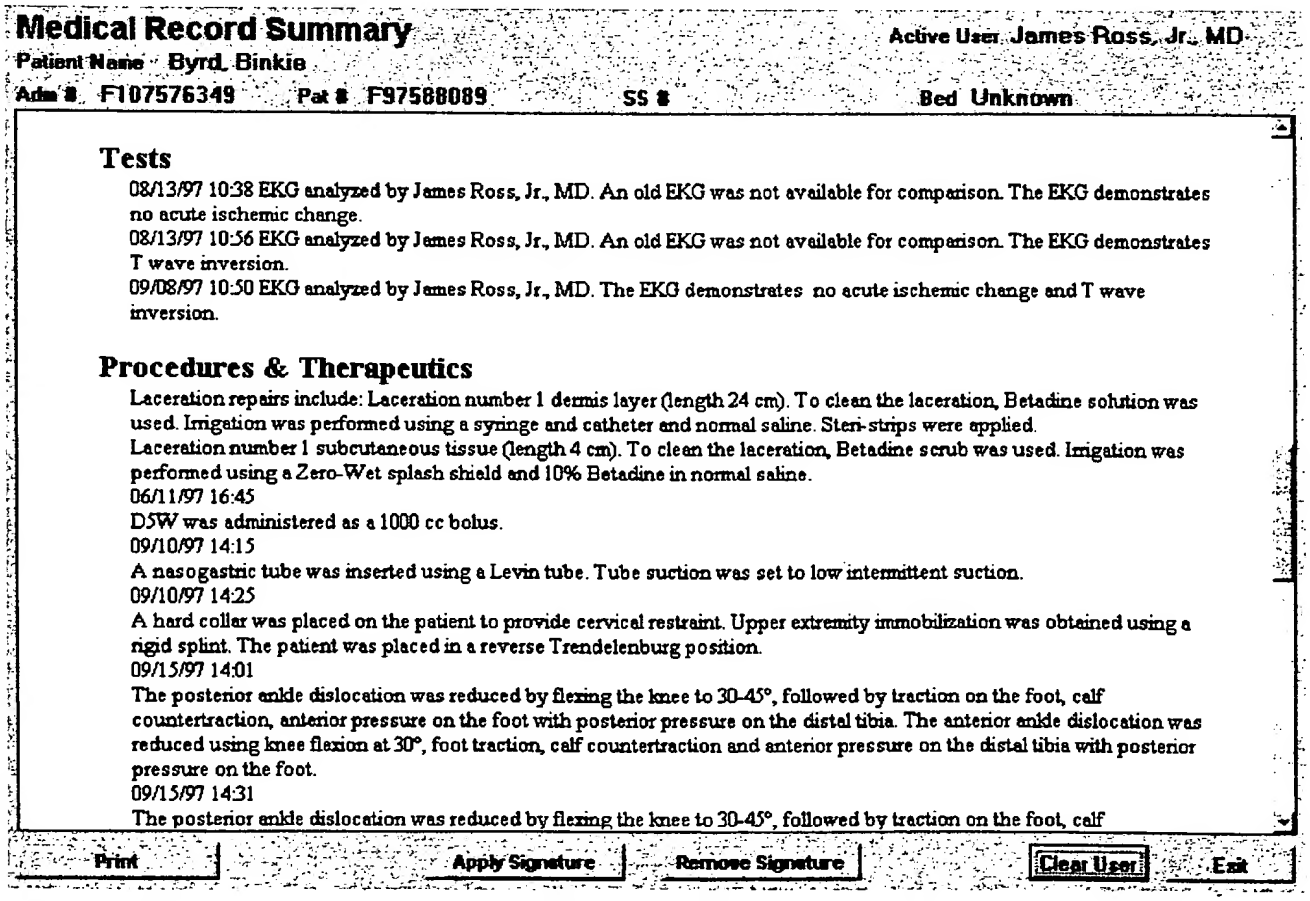


Figure Chapter 3: -95: Medical Record Summary

(Image: medical-record-summary-5.bmp)

4. Click the Scroll Bar to view additional information.

5. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Test Requests

- The **Prephrased Text** function (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Test Requests (comments, not requests) text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.

- ***Alternate access to this screen***
  X-Ray screen

Procedures & Therapeutics

Ordering/Documenting Therapeutic Procedures (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Therapeutics button in the INPUT section.

4. Select the appropriate Procedure then click on check boxes and form fields to complete as appropriate. (ACLS/CPR example follows)

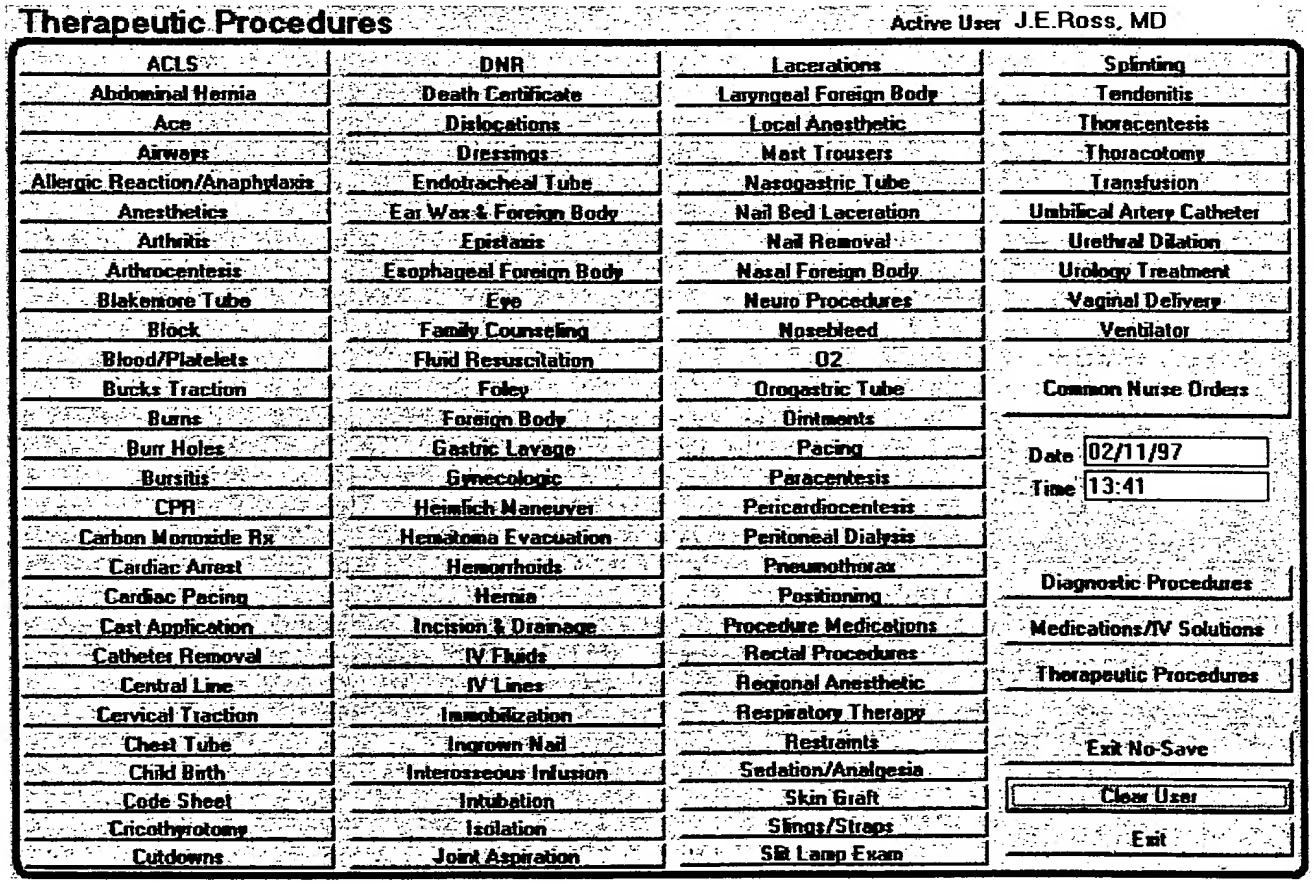


Figure Chapter 3: -96: Therapeutic Procedures

(Image: therapeutic-procedures.bmp)

ACLS/CPR: Screen 1

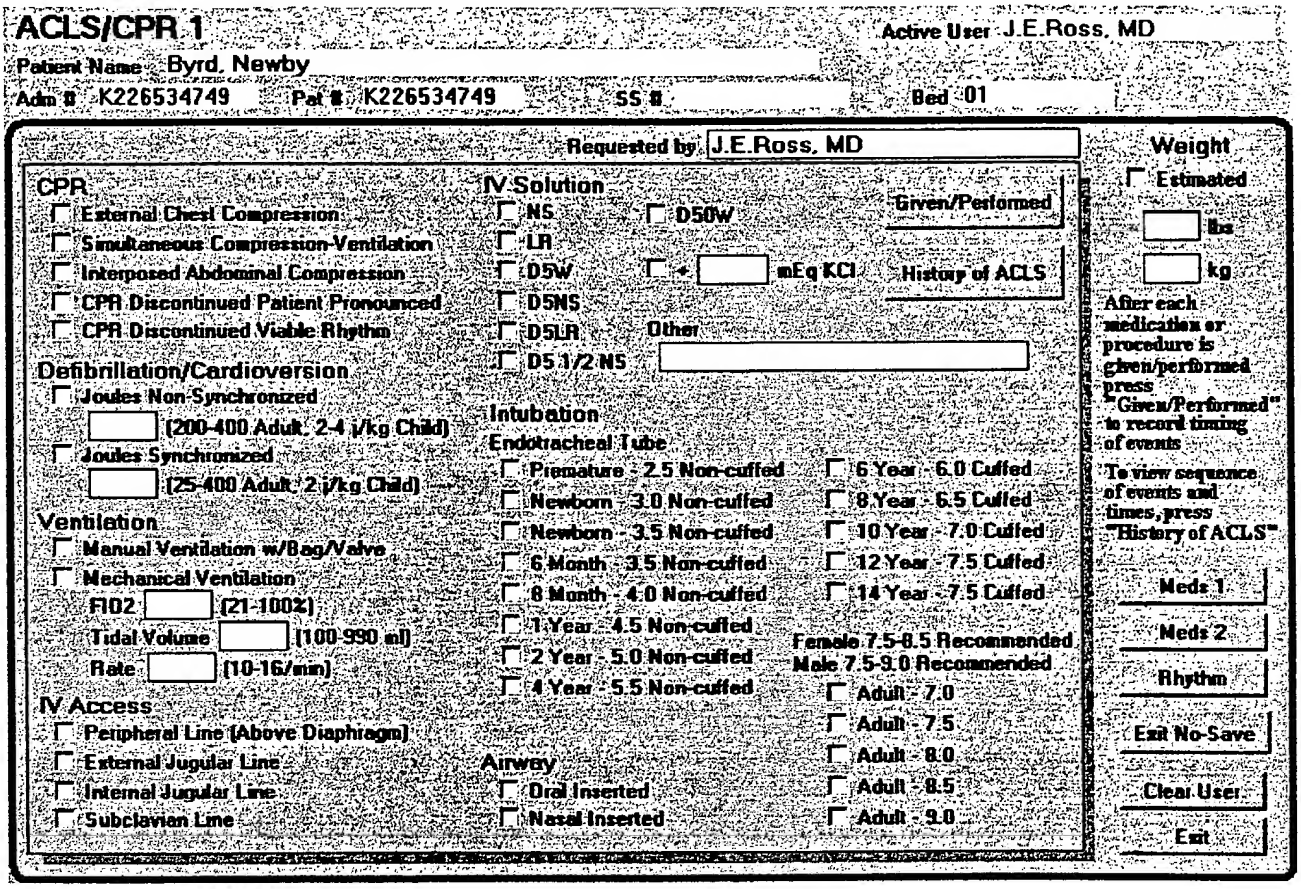


Figure Chapter 3: -97: ACLS/CPR - 1

(Image: acls-cpr-1.bmp)

5a. Click on check boxes and form fields to complete as appropriate then click on **Given/Performed** button to log the event/treatment.

- Click on the **History of ACLS** button to view the log of ACLS/CPR events/treatments.
- Click on Meds 1, Meds 2 and/or Rhythm buttons to access additional ACLS/CPR screens.

6. Click the Exit button to save updated patient information.

ACLS/CPR: Medications 1

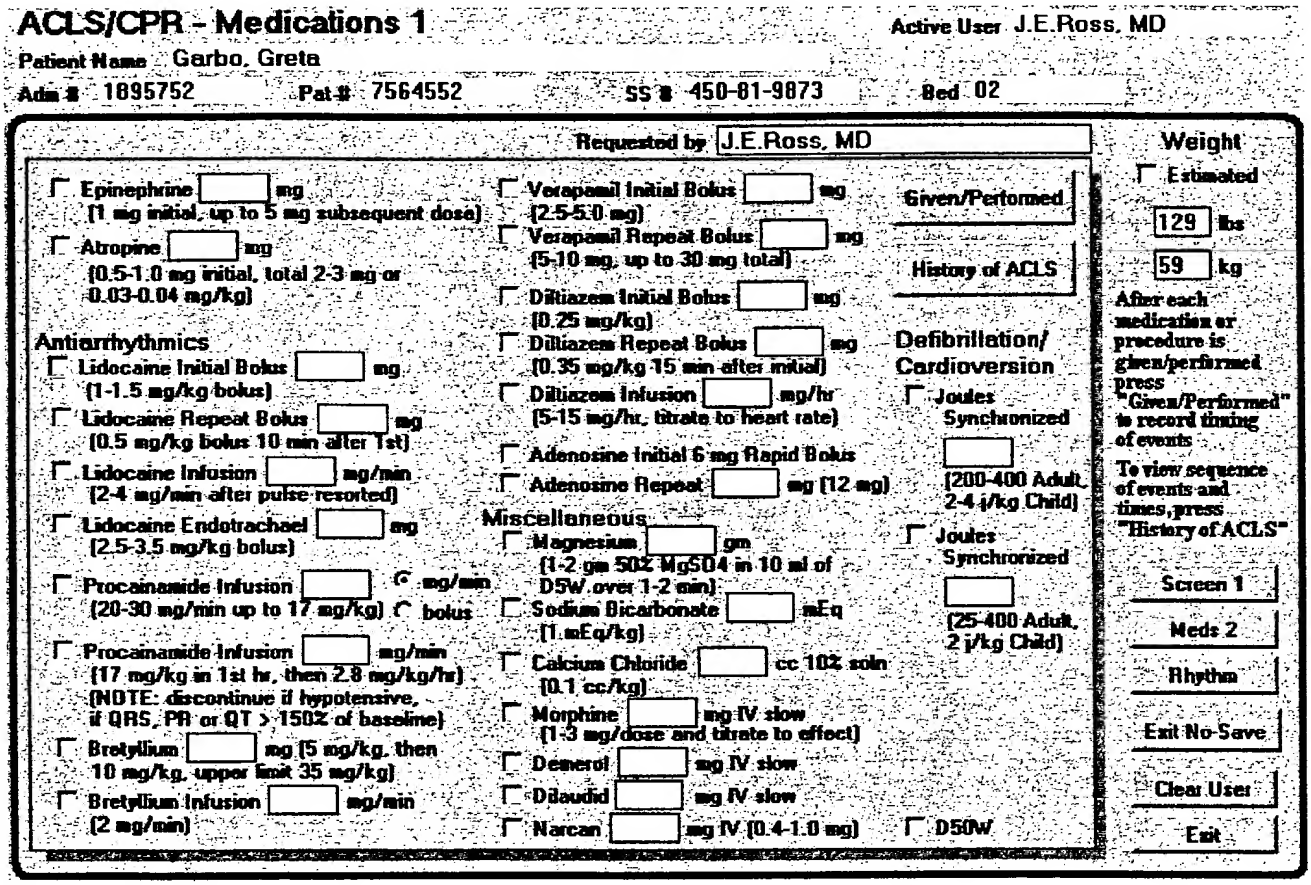
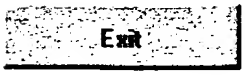


Figure Chapter 3: -98: ACLS/CPR - Medications 1

(Image: acls-cpr-1.bmp)

5b. Click on check boxes and form fields to complete as appropriate then click on **Given/Performed** button to log the event/treatment.

- Click on the **History of ACLS** button to view the log of ACLS/CPR events/treatments.
- Click on Screen 1, Meds 1, Meds 2 and/or Rhythm buttons to access additional ACLS/CPR screens.



6. Click the Exit button to save updated patient information.

ACLS/CPR: Medications 2

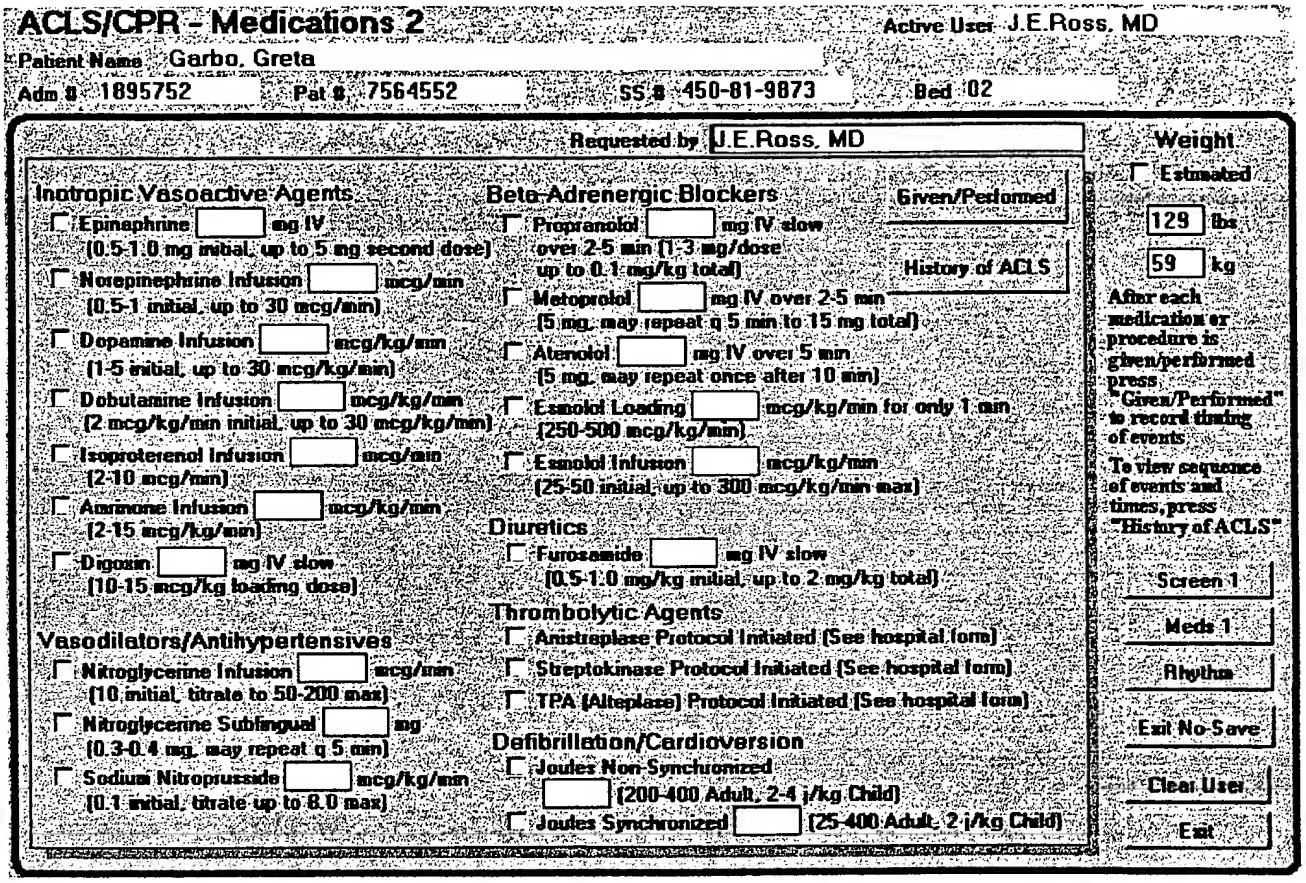


Figure Chapter 3: -99: ACLS/CPR - Medications 2

(Image: acls-cpr-medications2.bmp)

5c. Click on check boxes and form fields to complete as appropriate then click on **Given/Performed** button to log the event/treatment.

- Click on the **History of ACLS** button to view the log of ACLS/CPR events/treatments.
- Click on Screen 1, Meds 1 and/or Rhythm buttons to access additional ACLS/CPR screens.

6. Click the Exit button to save updated patient information.

ACLS/CPR: Rhythm

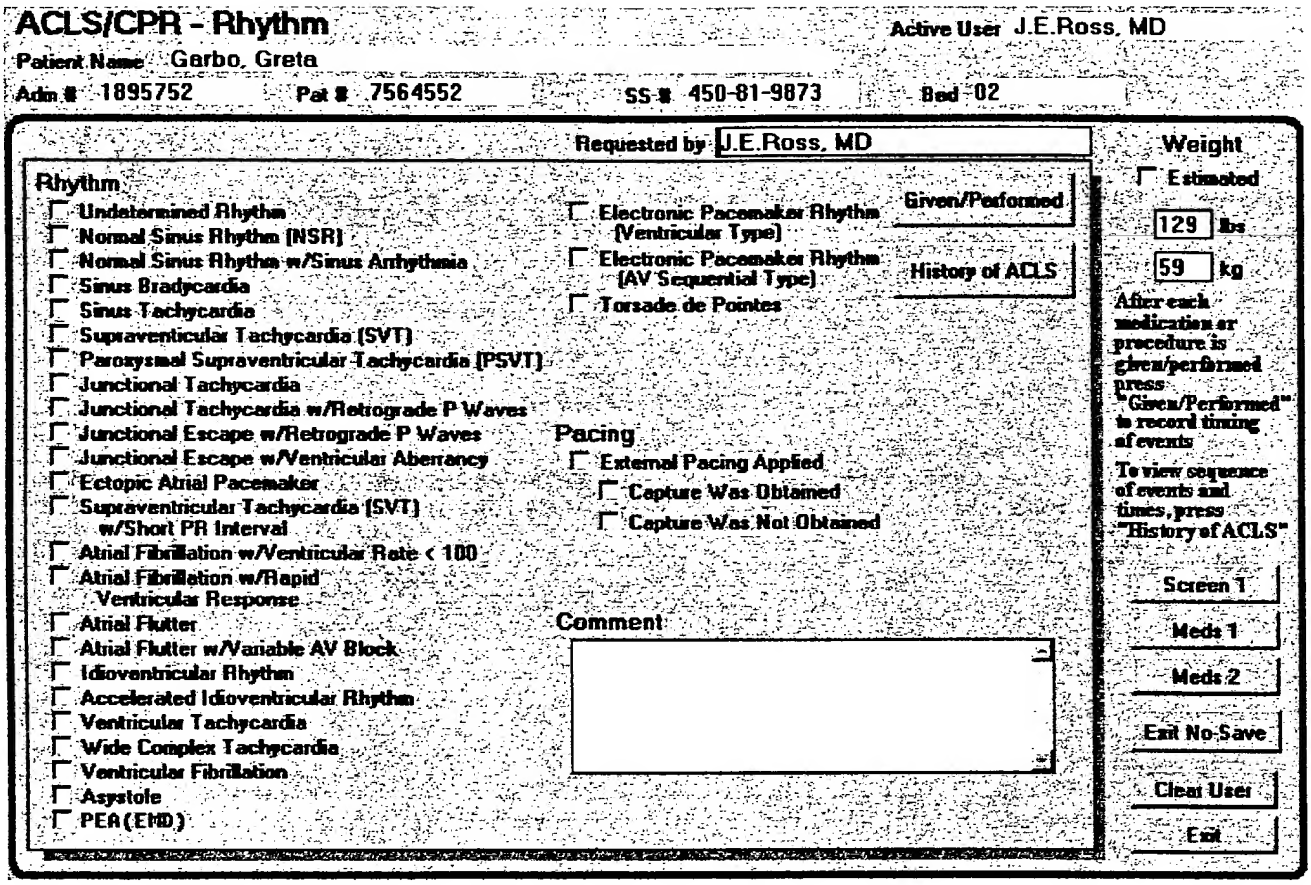


Figure Chapter 3: -100: ACLS/CPR - Rhythm

(Image: acls-cpr-rhythm.bmp)

5a. Click on check boxes and form fields to complete as appropriate then click on **Given/Performed** button to log the event/treatment.

- Click on the **History of ACLS** button to view the log of ACLS/CPR events/treatments.
- Click on Screen 1, Meds 1, and/or Meds 2 buttons to access additional ACLS/CPR screens.

6a. Click the Exit button to save updated patient information.

Ordering/Documenting Diagnostic Procedures (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Diagnostic Procedures button in the INPUT section.

4. Select the appropriate Procedure. (Eye Exam/Treatment sample follows)

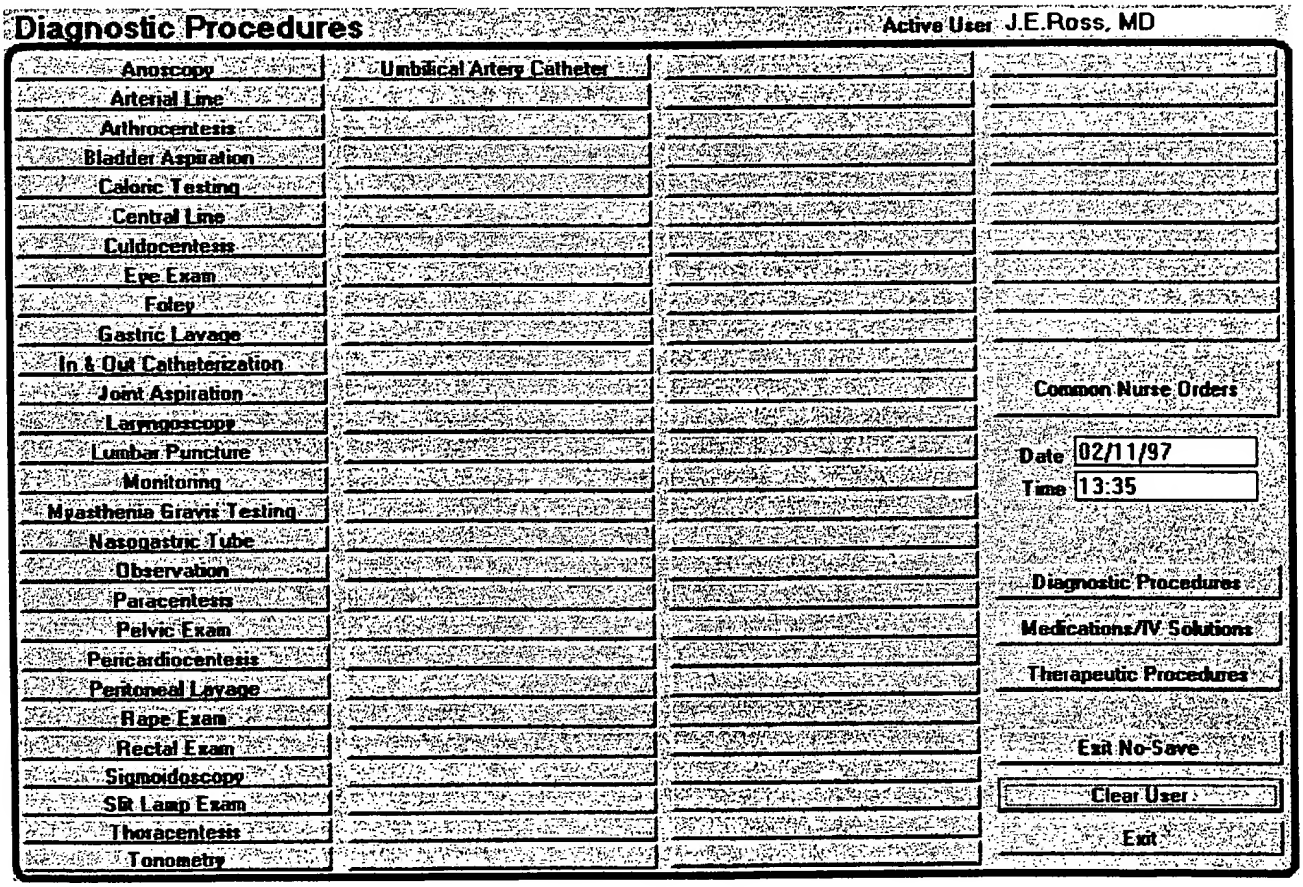


Figure Chapter 3: -101: Diagnostic Procedures

(Image: diagnostic -procedures.bmp)

5. Click the Exit button to save updated patient information.

Diagnostic Procedures Screen: Eye Exam/Treatment

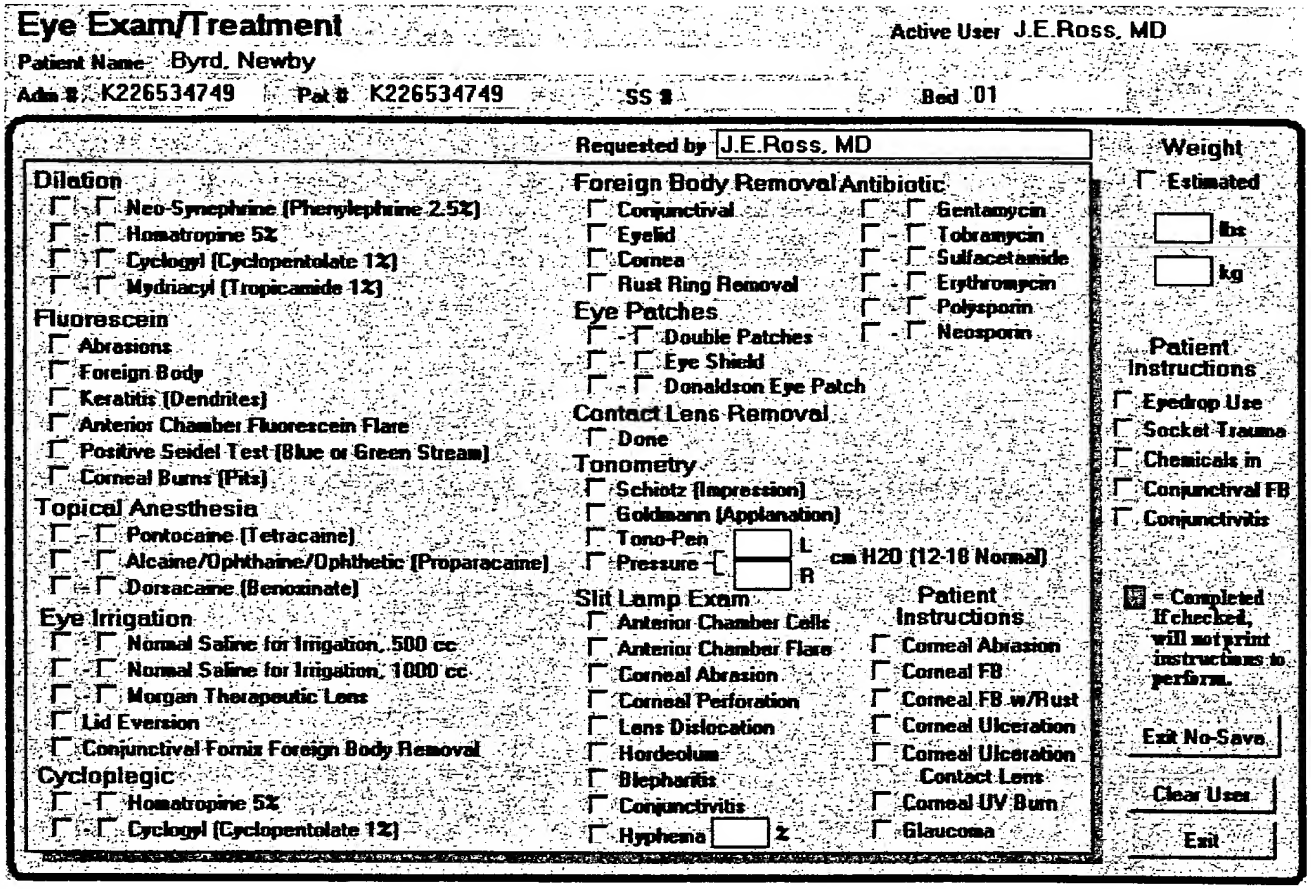


Figure Chapter 3: -102: Eye Exam/Treatment

(Image: eye-exam-treatment.bmp)

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Entering Procedures & Therapeutics Comments (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Transcript Editor button in the HISTORICAL section.

4a) Entering a new Procedures & Therapeutics comment entry:

- Click on To Add button.
- Open the pull down menu and select "Procedures & Therapeutics".

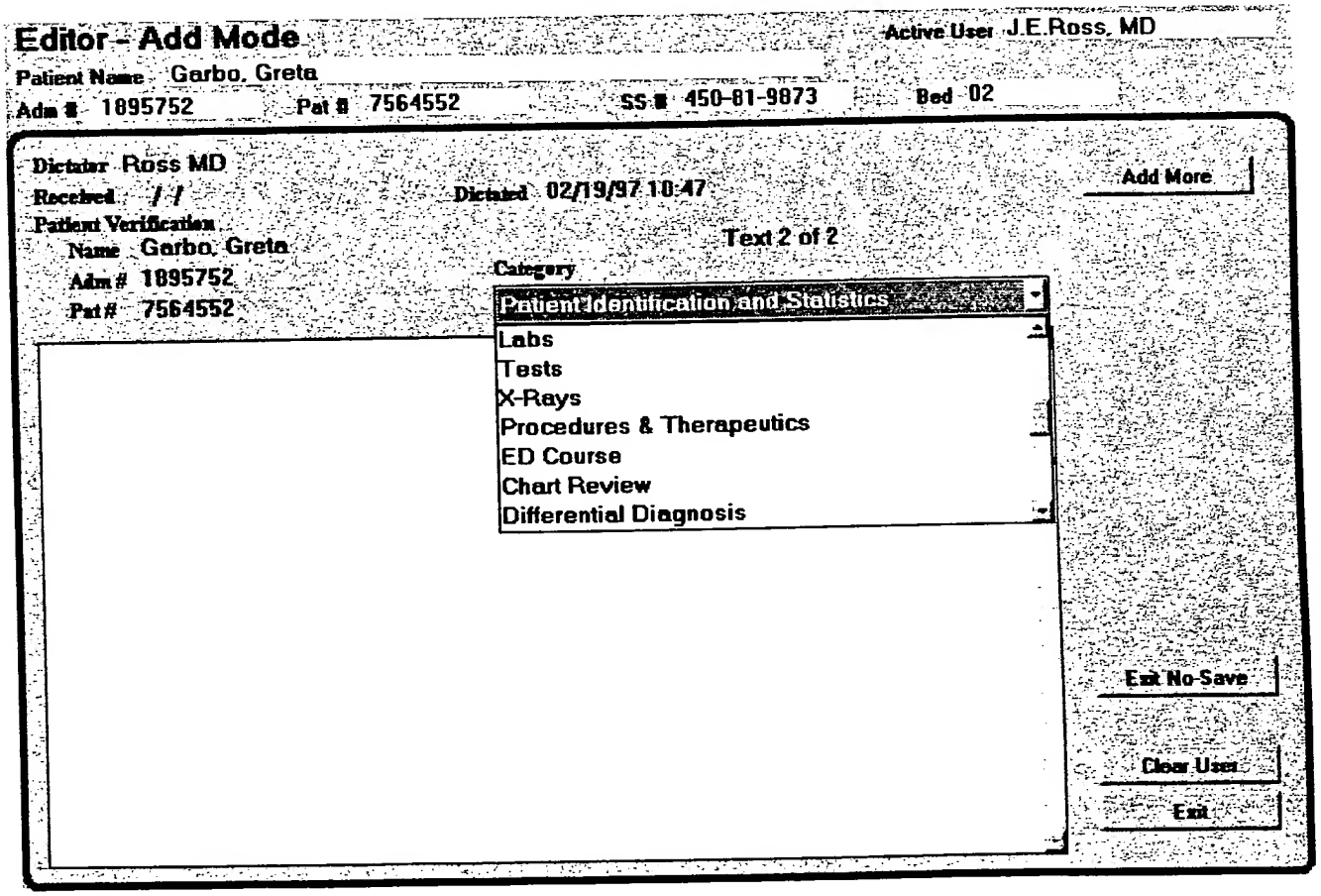


Figure Chapter 3: -103: Procedures & Therapeutics (in Editor Add Mode)

(Image: editor-add-mode-5.bmp)

Entering/Modifying Procedures & Therapeutics comments (manual) *(continued)*

4b. Modify an existing Procedures & Therapeutics comment entry:

- Click on Next / Prior (or First / Last) buttons to locate Procedures & Therapeutics.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

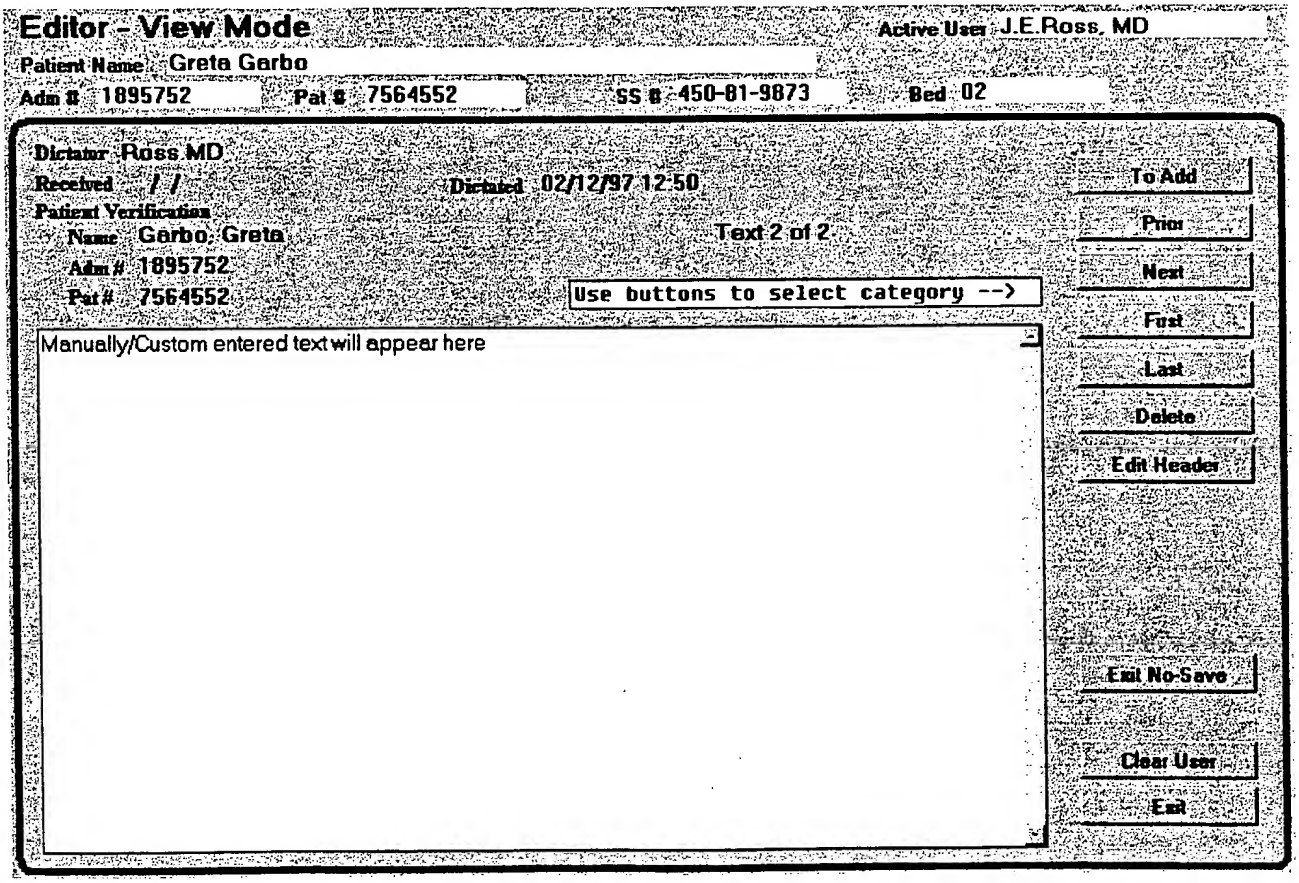


Figure Chapter 3: -104: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

6. Click the Exit button to save updated patient information.

Viewing Procedures & Therapeutics

→ **Option A**

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Therapeutics Summary button in the HISTORICAL section.

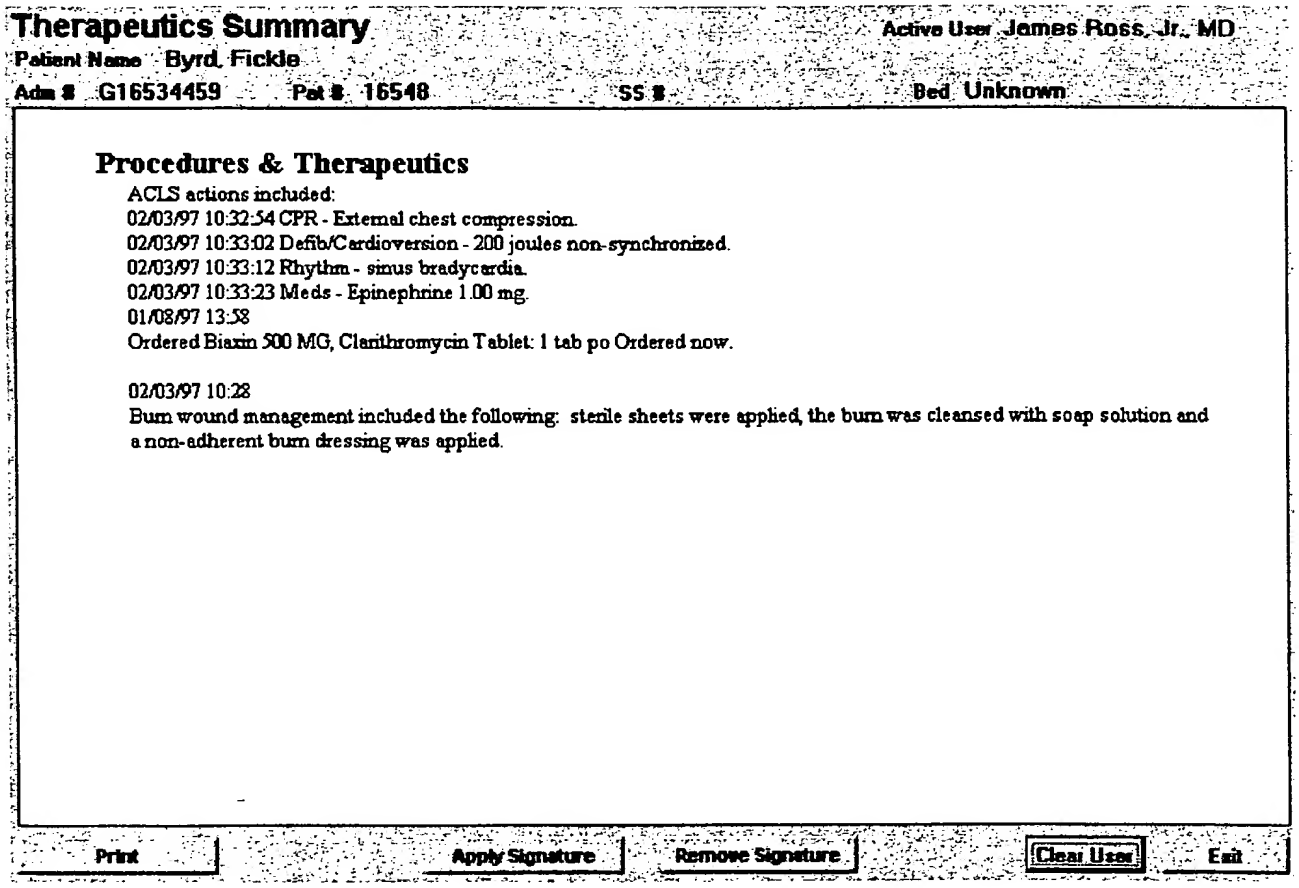
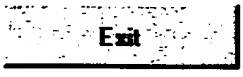


Figure Chapter 3: -105: Therapeutics Summary

(Image: therapeutics-summary.bmp)



4. Click the Exit button (twice) to return to the Medical Information screen.

Viewing Procedures & Therapeutics *(continued)*

→ **Option B**

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Summary button in the HISTORICAL section. [brings you to the Medical Record Summary]

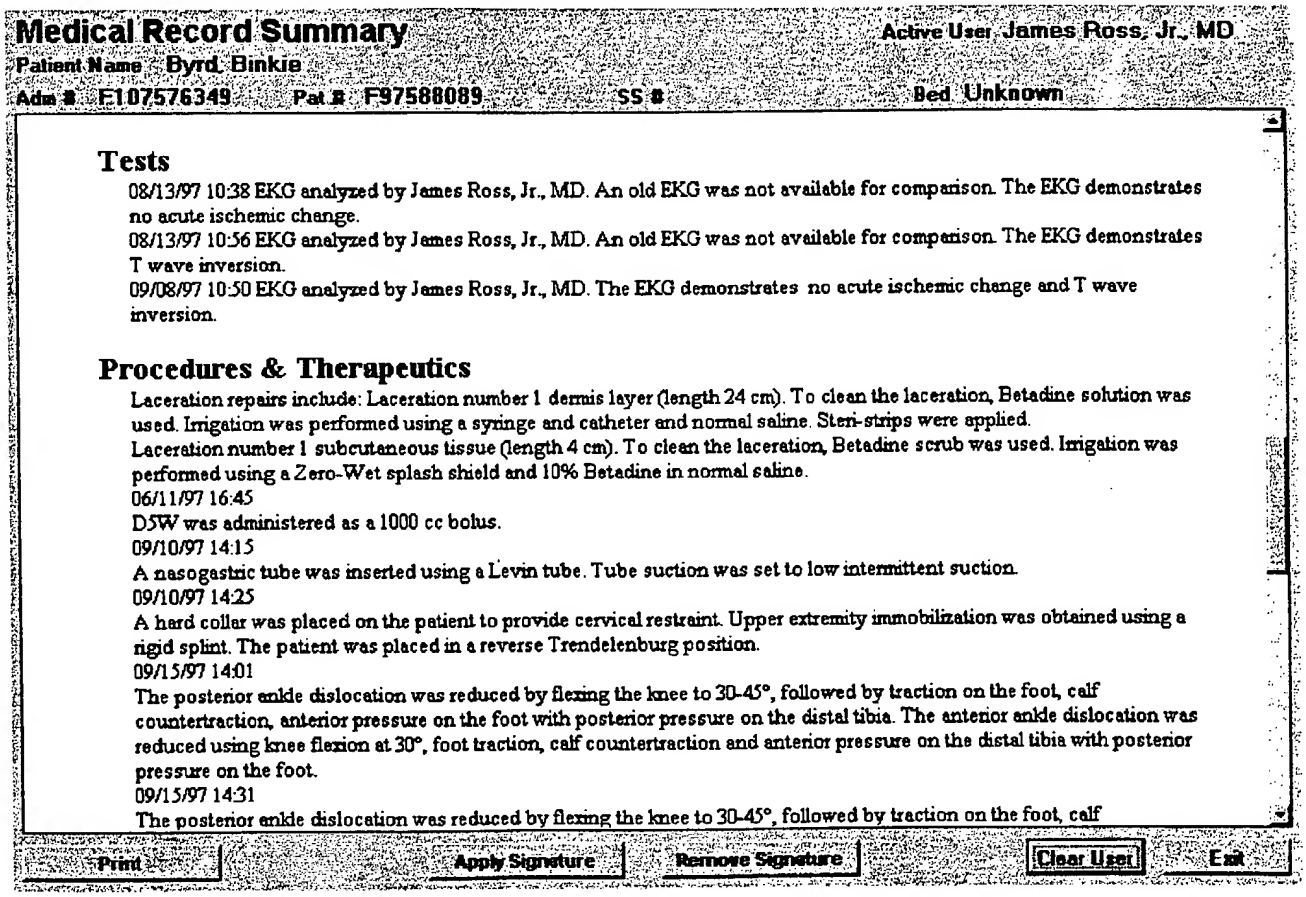


Figure Chapter 3: -106: Medical Record Summary

(Image: medical-record-summary-5.bmp)

4. Click the Scroll Bar to view additional information.

5. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Documenting Therapeutic Procedures

- The **Prephrased Text** function (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Therapeutic Procedures (comments, not requests) text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.

- ***Alternate access to these screens***
  Therapeutics & Diagnostic Procedures & Medications screens

Medications in the ER

Ordering Medications in the ER - Drugs (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Medications in ER button in the INPUT section.

4. Select the appropriate Drugs(s) from the Select Drug screen. (Keflet sample follows)

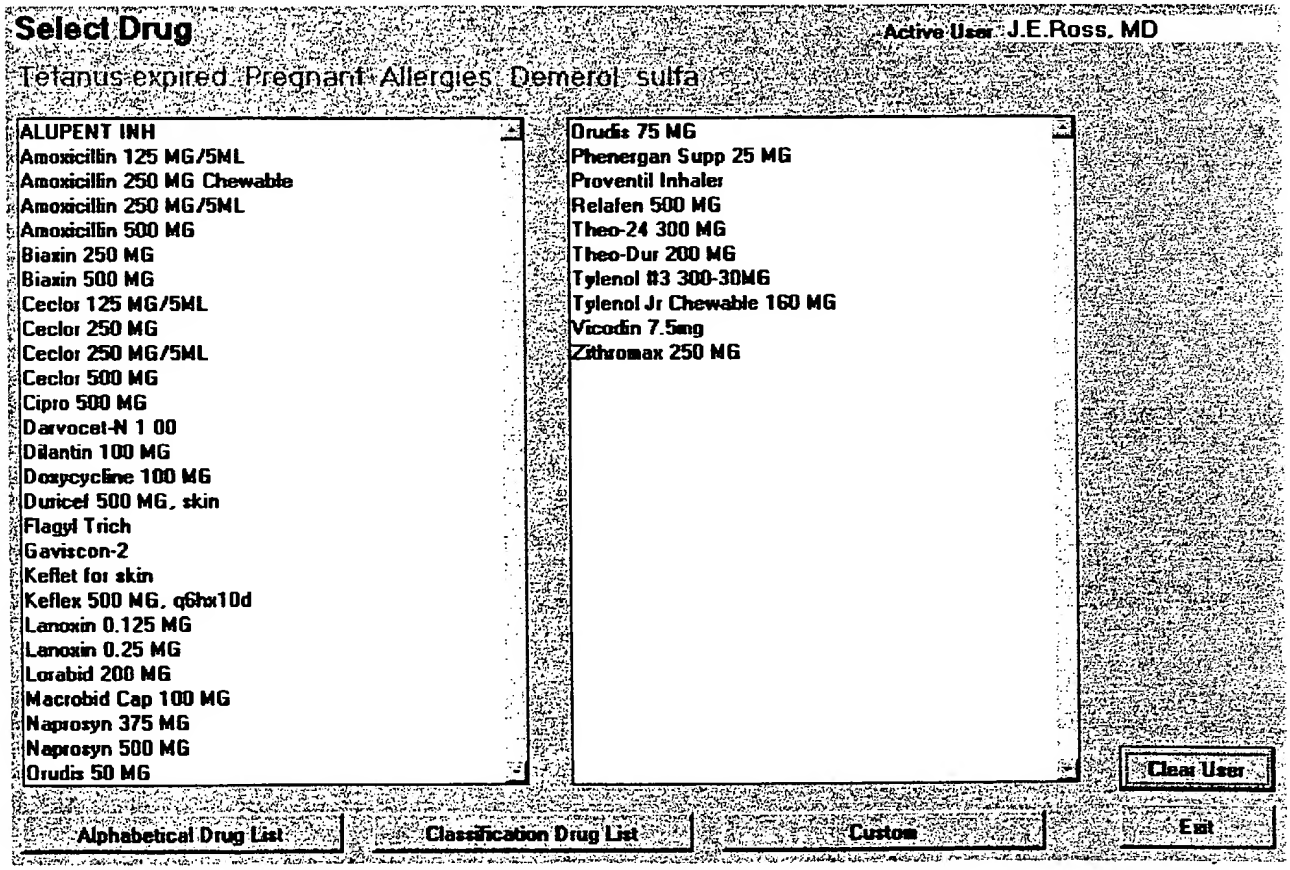
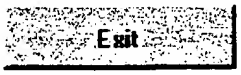


Figure Chapter 3: -107: Select Drug

(Image: select-drug.bmp)



5. Click the Exit button to save updated patient information.

Medications in the ER: Keflet Screen

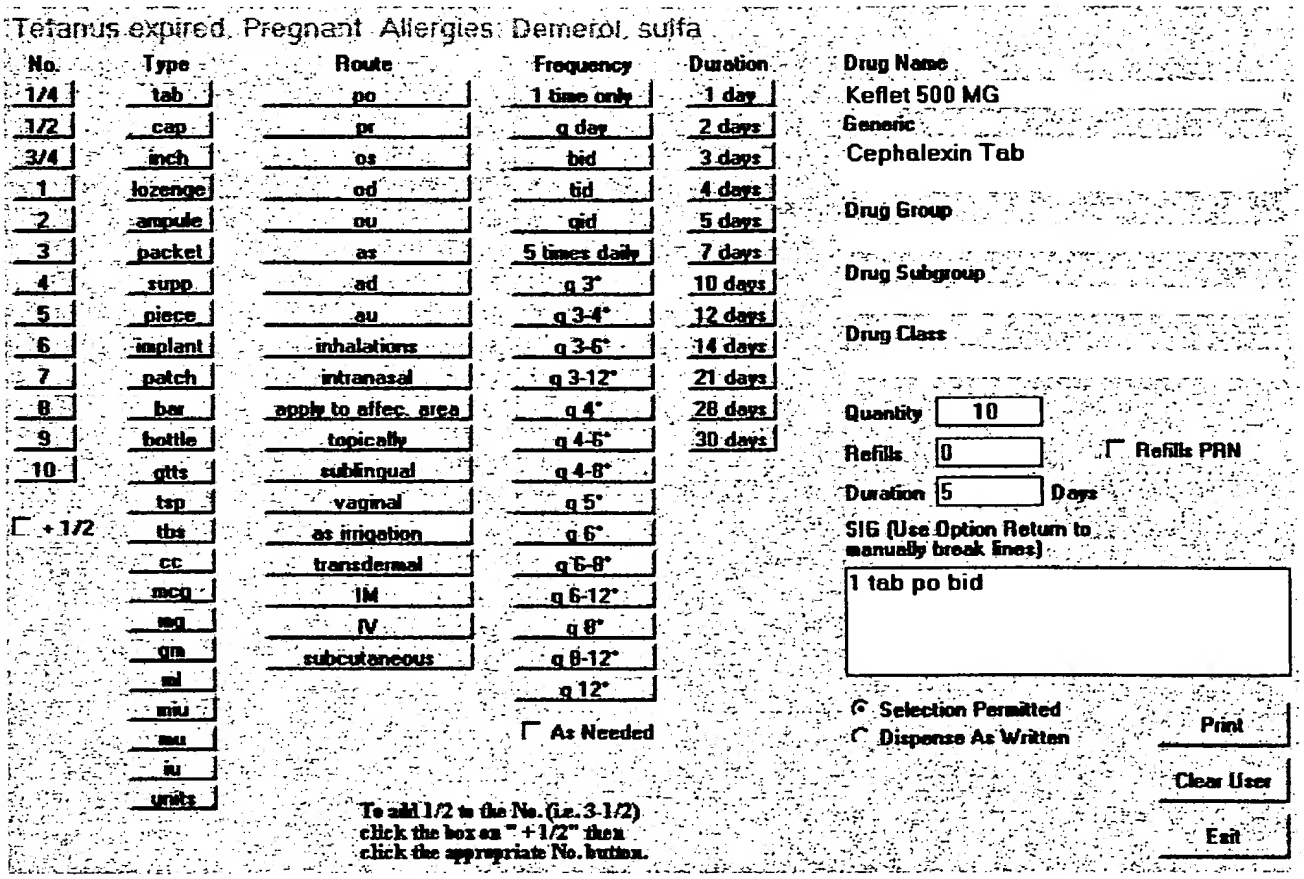


Figure Chapter 3: -108: Typical Drug Selection Screen

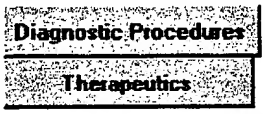
(Image: prescription-keflet.bmp)

Ordering Medications in the ER - Medications/IV Solutions (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.



3. Click on either Diagnostic Procedures or Therapeutics button in the INPUT section.

4. Click the appropriate Procedure and then click on check boxes and form fields in the subsequent menus to complete as appropriate. (Medications/IV Solutions sample follows)

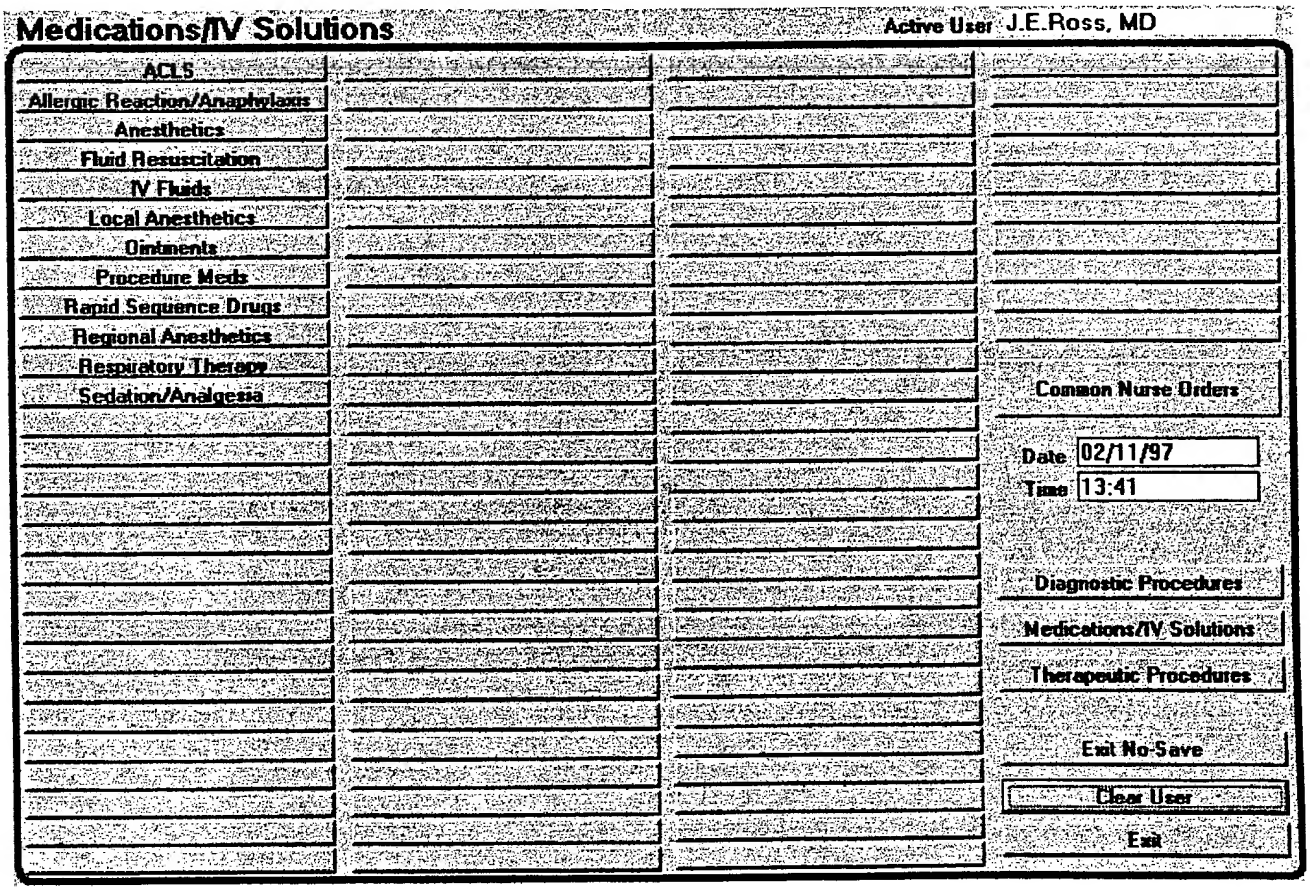


Figure Chapter 3: -109: Medications/IV Solutions

(Image: medications-iv-solutions.bmp)

5. Click the Exit button to save updated patient information.

Entering Medications in the ER Comments (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Transcript Editor button in the HISTORICAL section.

4a) Entering a new Medications comment entry:

- Click on To Add button.
- Open the pull down menu and select "Medications".

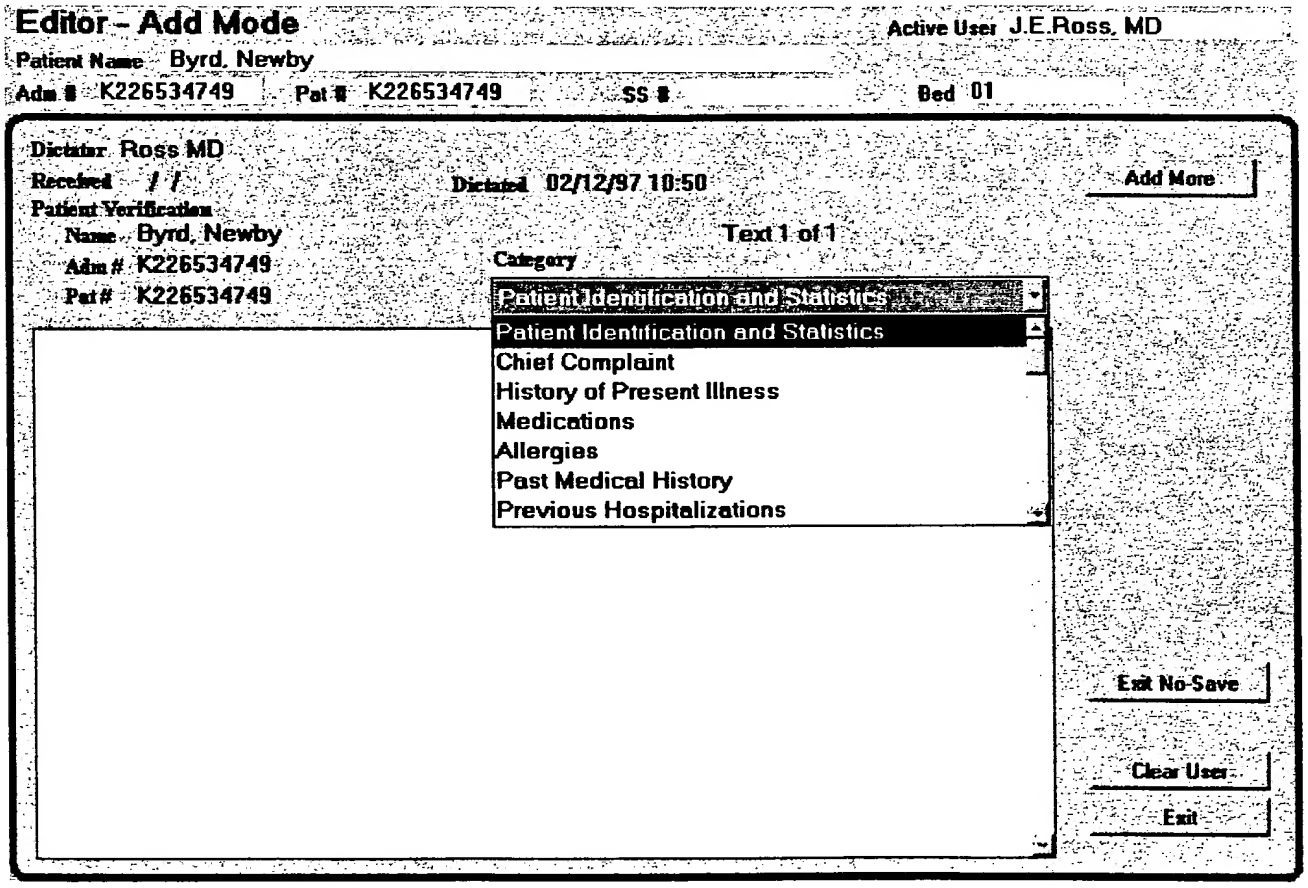


Figure Chapter 3: -110: Medications (in Editor Add Mode)

(Image: editor-add-mode-1.bmp)

Entering/Modifying Medications in the ER comments (manual) *(continued)*

4b. Modify an existing Medications comment entry:

- Click on Next / Prior (or First / Last) buttons to locate Medications.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

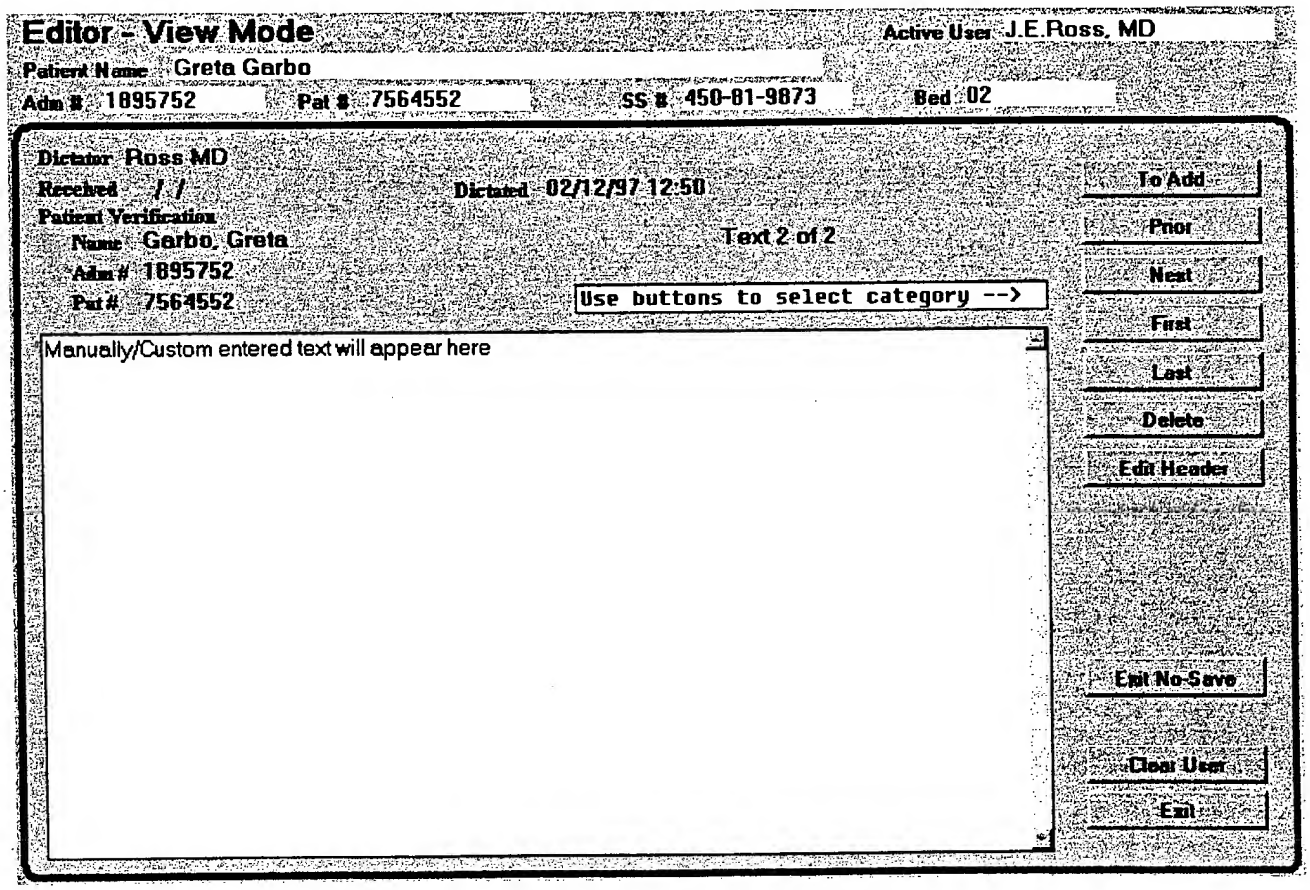


Figure Chapter 3: -111: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

6. Click the Exit button to save updated patient information.

Viewing Medications in the ER

→ **Option A**

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Therapeutics Summary button in the HISTORICAL section.

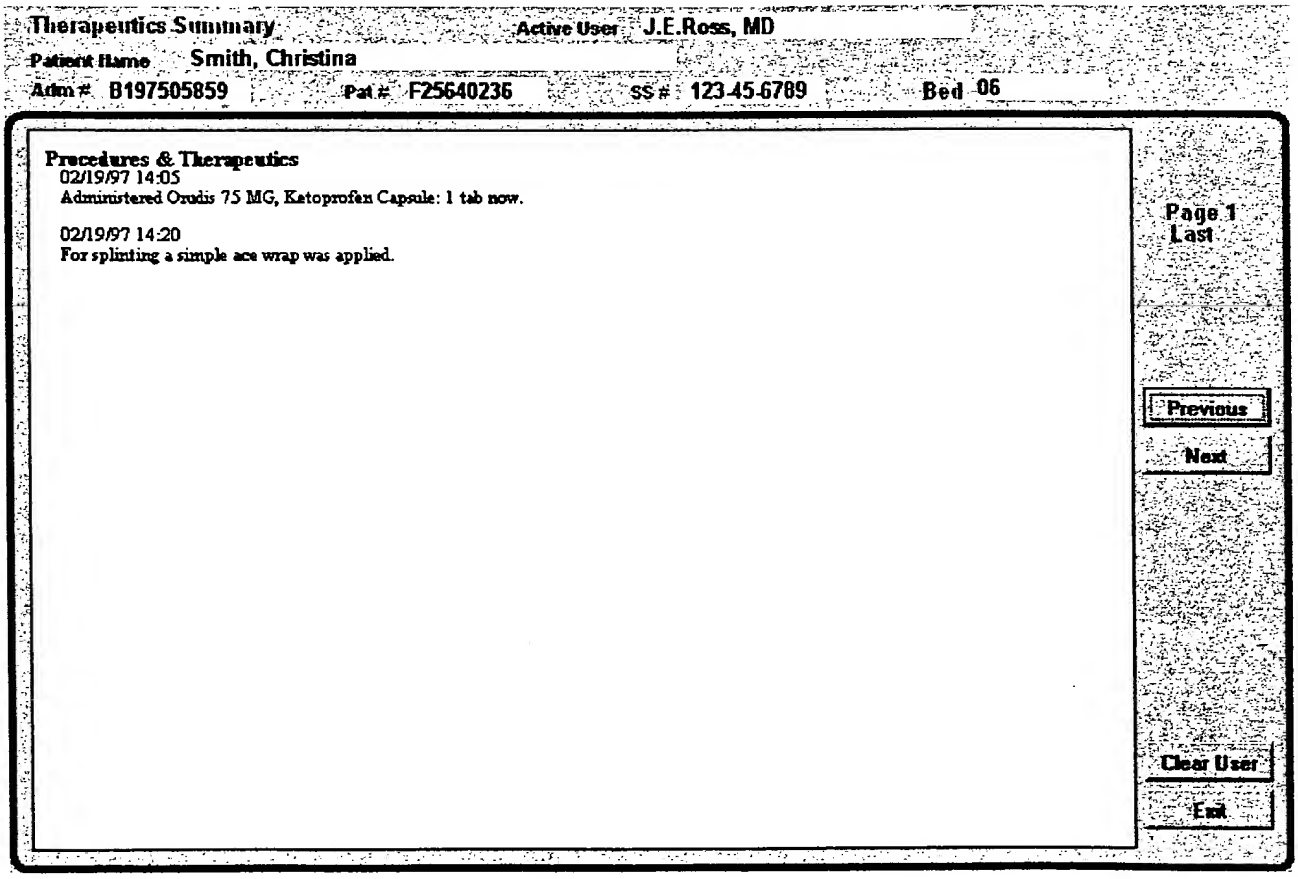
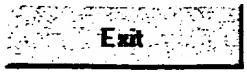


Figure Chapter 3: -112: Therapeutics Summary (with Medications in ER)

(Image: therapeutics-summary.bmp)



4. Click the Exit button (twice) to return to the Medical Information screen.

Viewing Medication in the ER *(continued)*

→ **Option B**

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Summary button in the HISTORICAL section. [brings you to the Medical Record Summary]

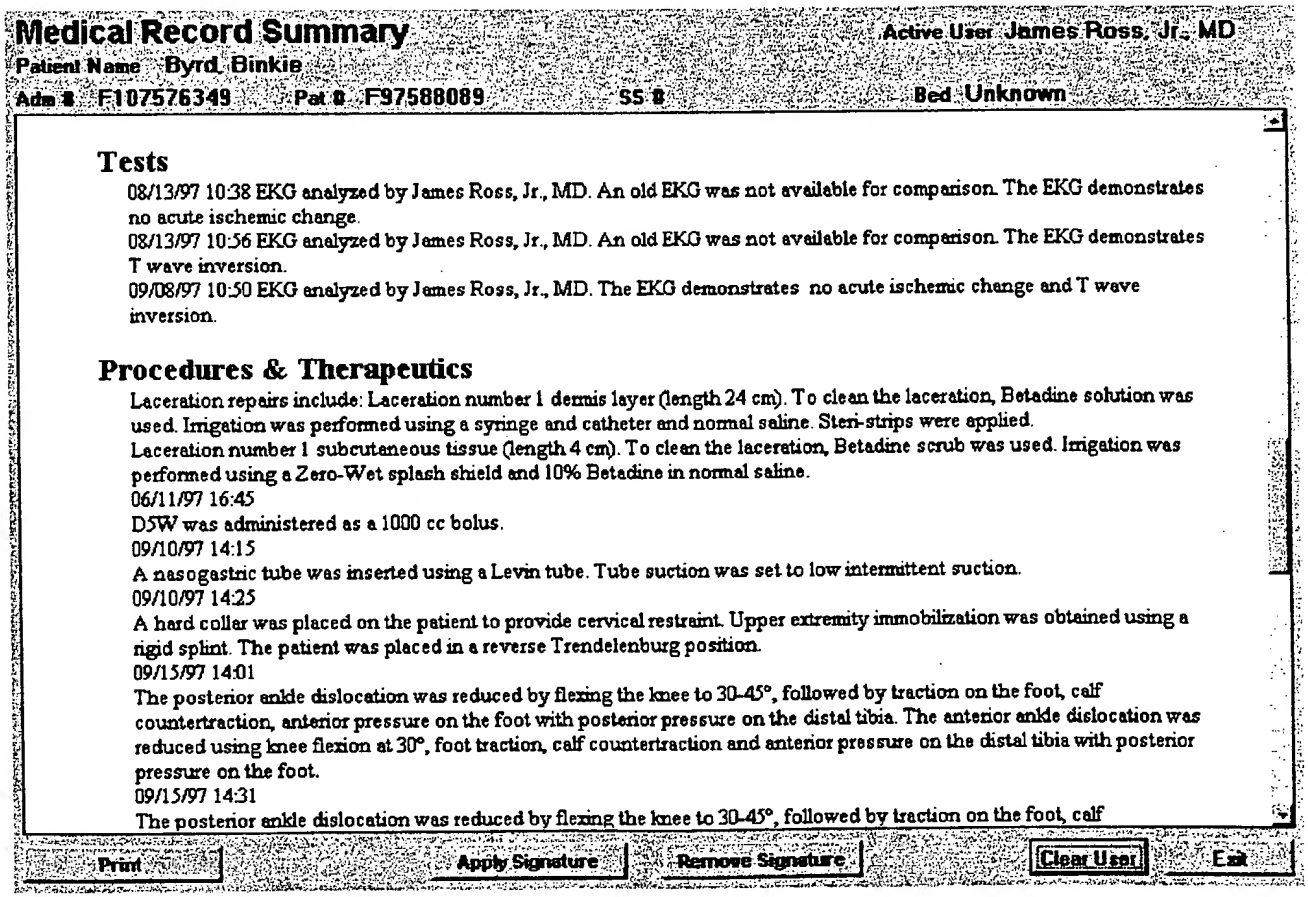
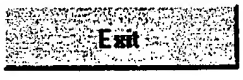


Figure Chapter 3: -113: Medical Record Summary

(Image: medical-record-summary-5.bmp)

4. Click the Scroll Bar to view additional information.



5. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Ordering Medications in the ER

- The **Prephrased Text** function (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Medications (comments, not requests) text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.

- ***Alternate access to these screens***
  Therapeutics & Diagnostic Procedures screens

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Referrals

Entering/Updating Referrals (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Referrals button in the INPUT section.

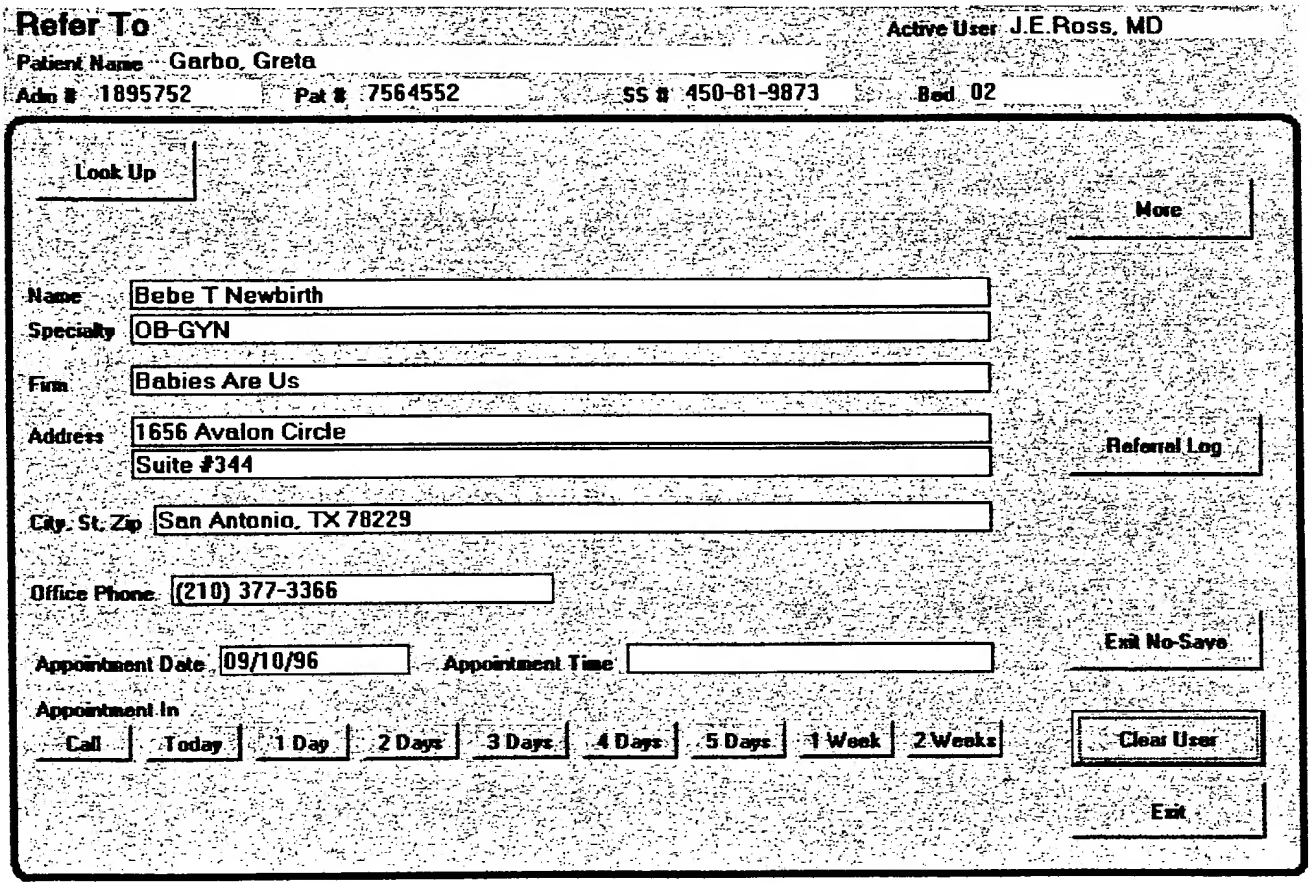


Figure Chapter 3: -114: Refer To

(Image: refer-to.bmp)

Entering/Updating Referrals (std. menu) *(continued)*

4a. Entering a new referral:

- Select form fields and complete as appropriate.
- Select Appointment in (via button or manual).
- The Look Up button provides an updateable list of local "referrals".

4b. Updating an existing referral:

- Click on the Referral Log button.
- Highlight the "referred to" name.
- Click the Edit button and update the form fields as required (see 4a.).

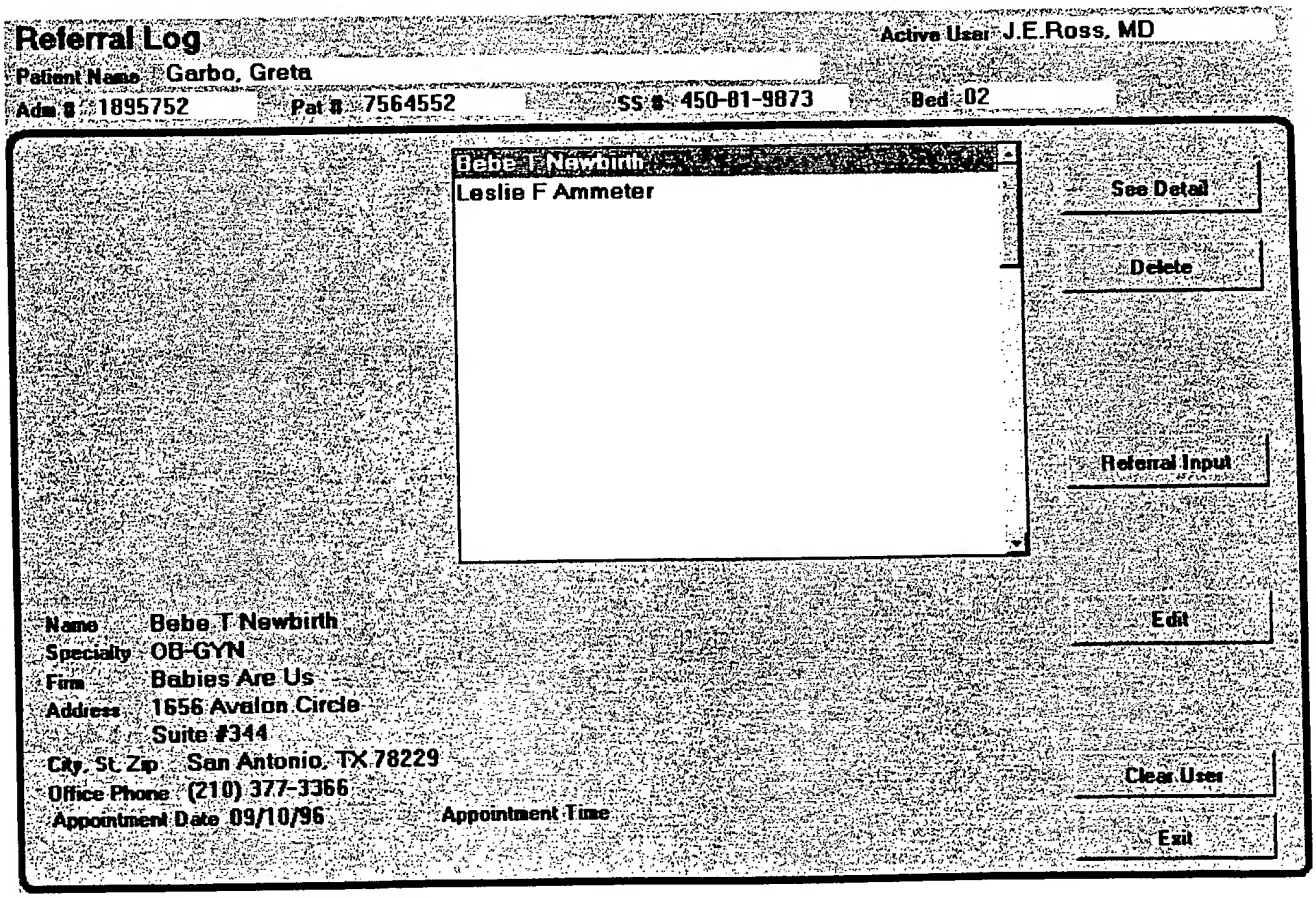
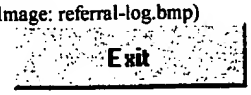


Figure Chapter 3: -115: Referral Log

(Image: referral-log.bmp)



5. Click the Exit button to save updated referral information.

Entering/Updating Referrals Comments (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Transcript Editor button in the HISTORICAL section.

4a) Entering a new Referrals comment entry:

- Click on To Add button.
- Open the pull down menu and select "Referrals".

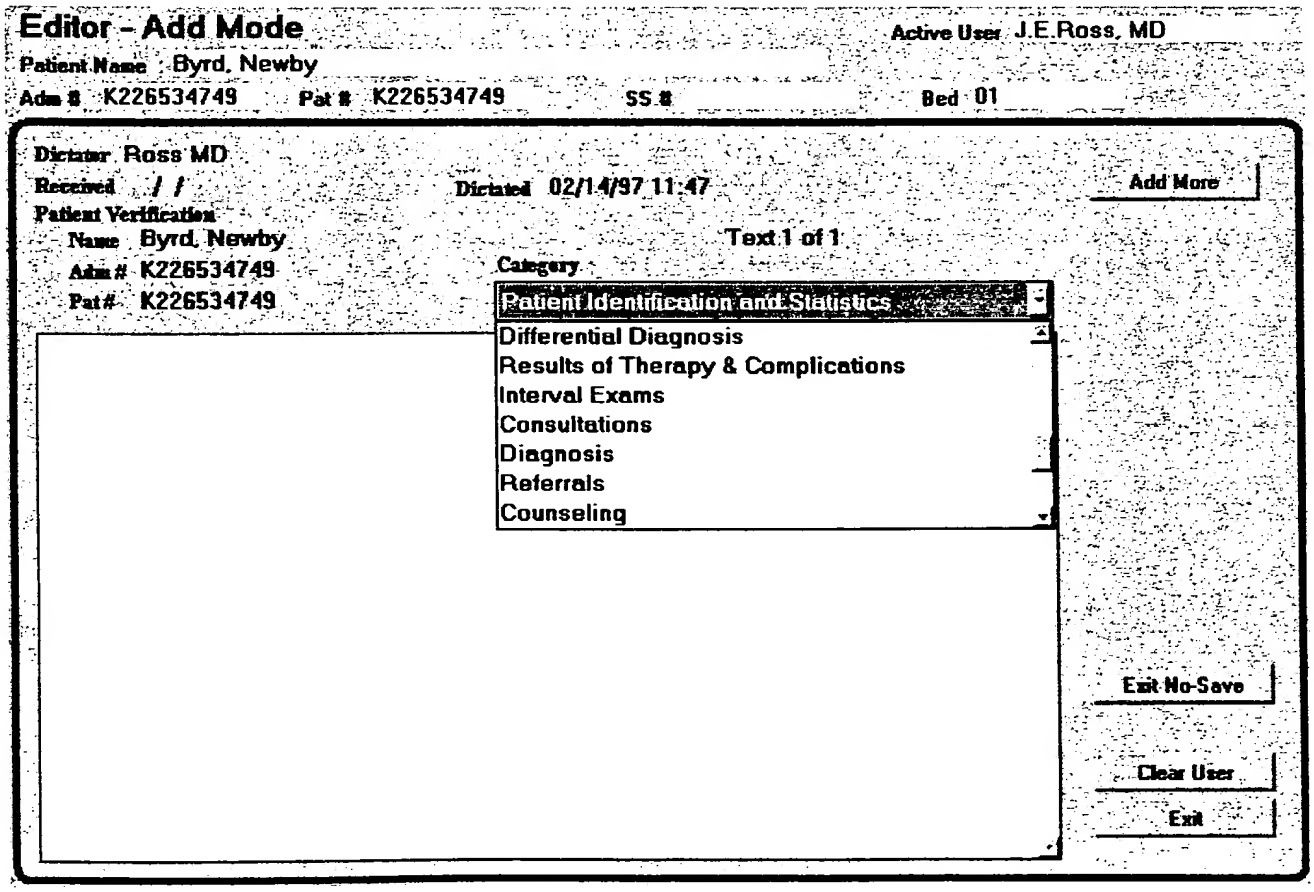


Figure Chapter 3: -116: Referrals (in Editor Add Mode)

(Image: editor-add-mode-4.bmp)

Entering/Modifying Referral Comments (manual) *(continued)*

4b. Modify an existing Referrals comment entry:

- Click on Next / Prior (or First / Last) buttons to locate Referrals.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

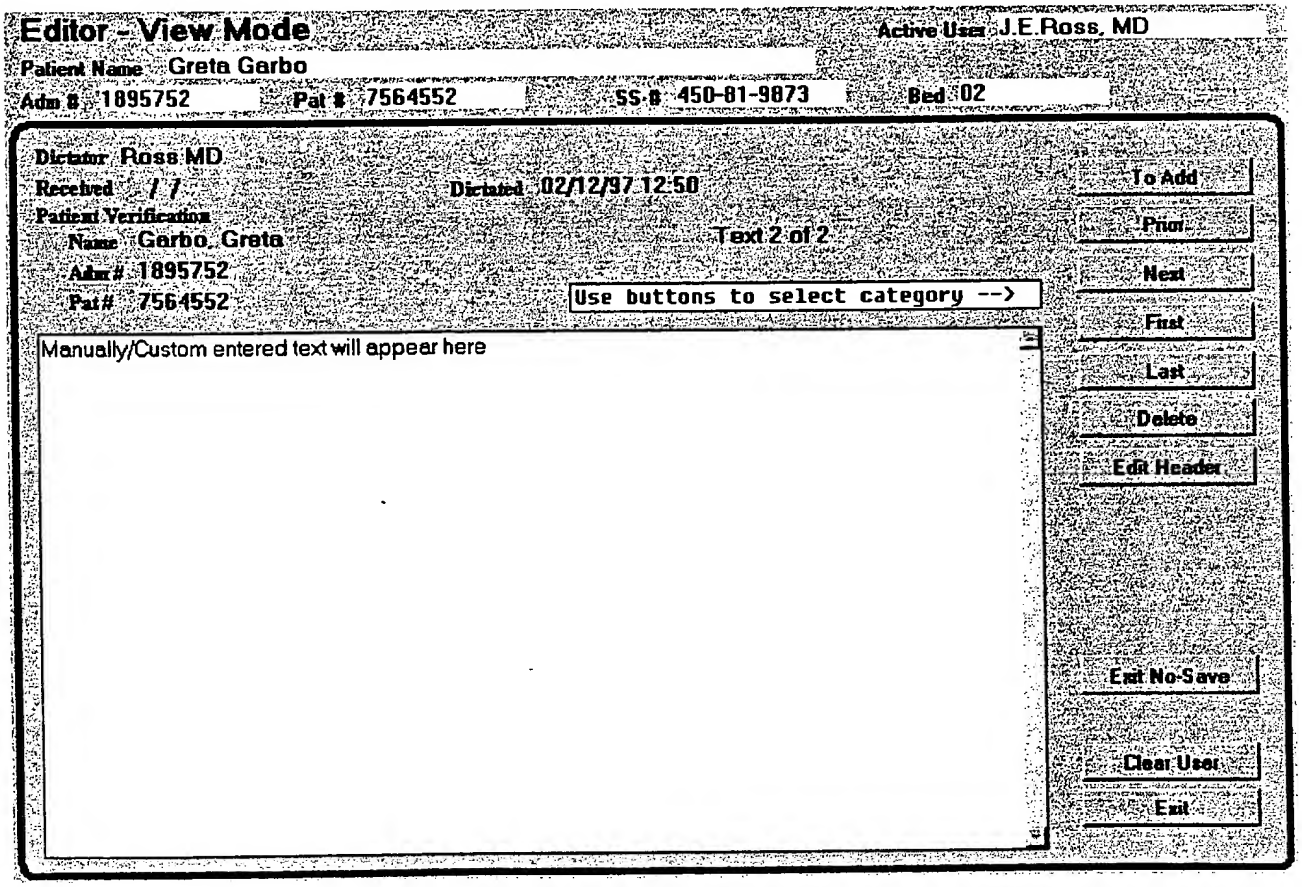


Figure Chapter 3: -117: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

6. Click the Exit button to save updated patient information.

Viewing Referrals

→ **Option A**

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Referral Log button in the HISTORICAL section.

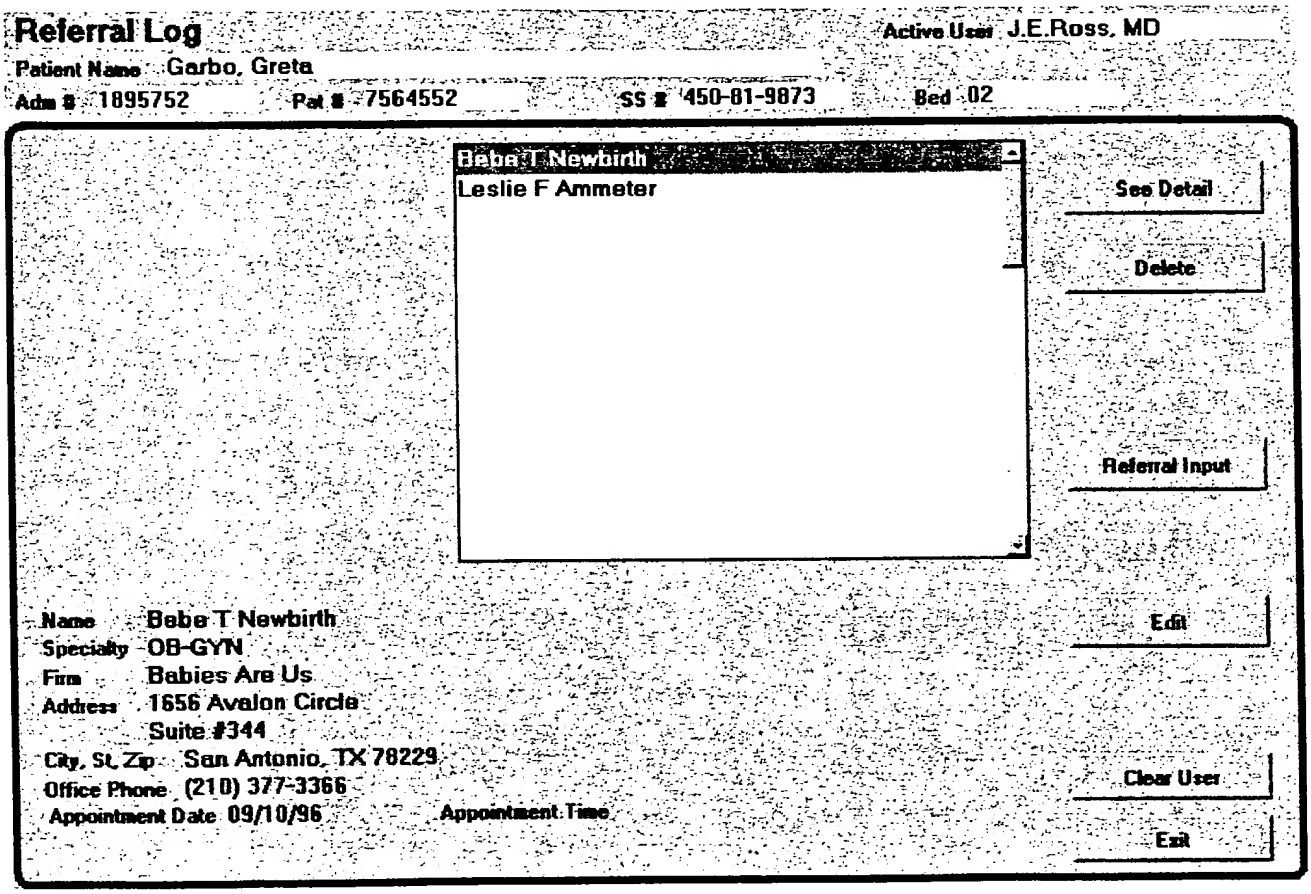


Figure Chapter 3: -118: Referral Log

(Image: referral-log.bmp)

4. Highlight the "referred to" name.
5. Click on the See Detail button.

6. Click the Exit button to return to the Medical Information screen.

Viewing Referrals *(continued)*

→ Option B

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Referrals button in the INPUT section.

4. Click on the Referral Log button

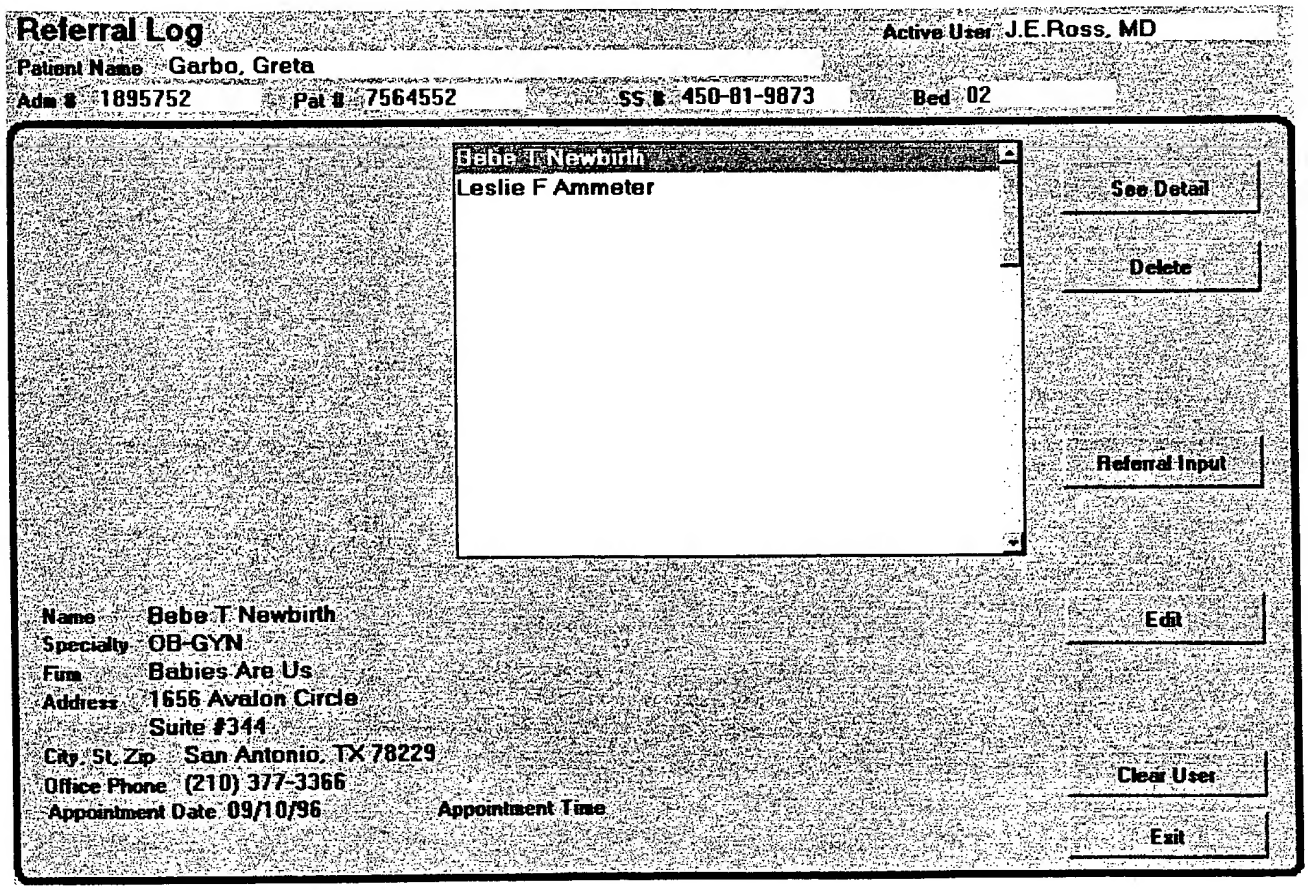


Figure Chapter 3: -119: Referral Log

(Image: referral-log.bmp)

5. Highlight the "referred to" name.
6. Click on the See Detail button.

7. Click the Exit button to return to the Medical Information screen.

Viewing Referrals *(continued)*

→ **Option C**

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Summary button in the HISTORICAL section. [brings you to the Medical Record Summary]

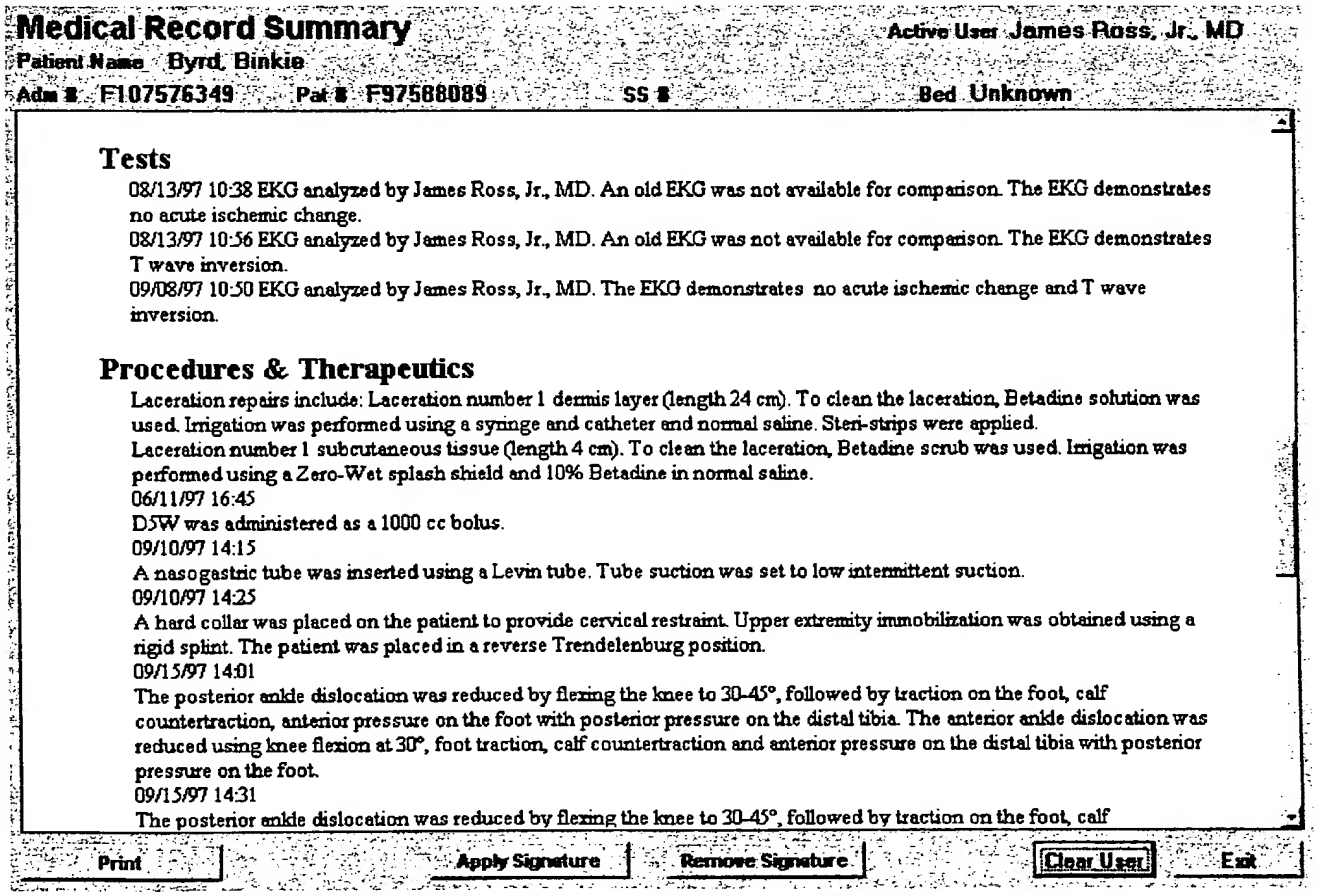
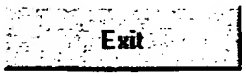


Figure Chapter 3: -120: Medical Record Summary

(Image: medical-record-summary-3.bmp)

4. Click the Scroll Bar to view additional information.



5. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Referrals

- The **Prephrased Text** function (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Referrals (comments, not requests) text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.

Consultations

Entering/Documenting Consultations (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Consultations button in the INPUT section.

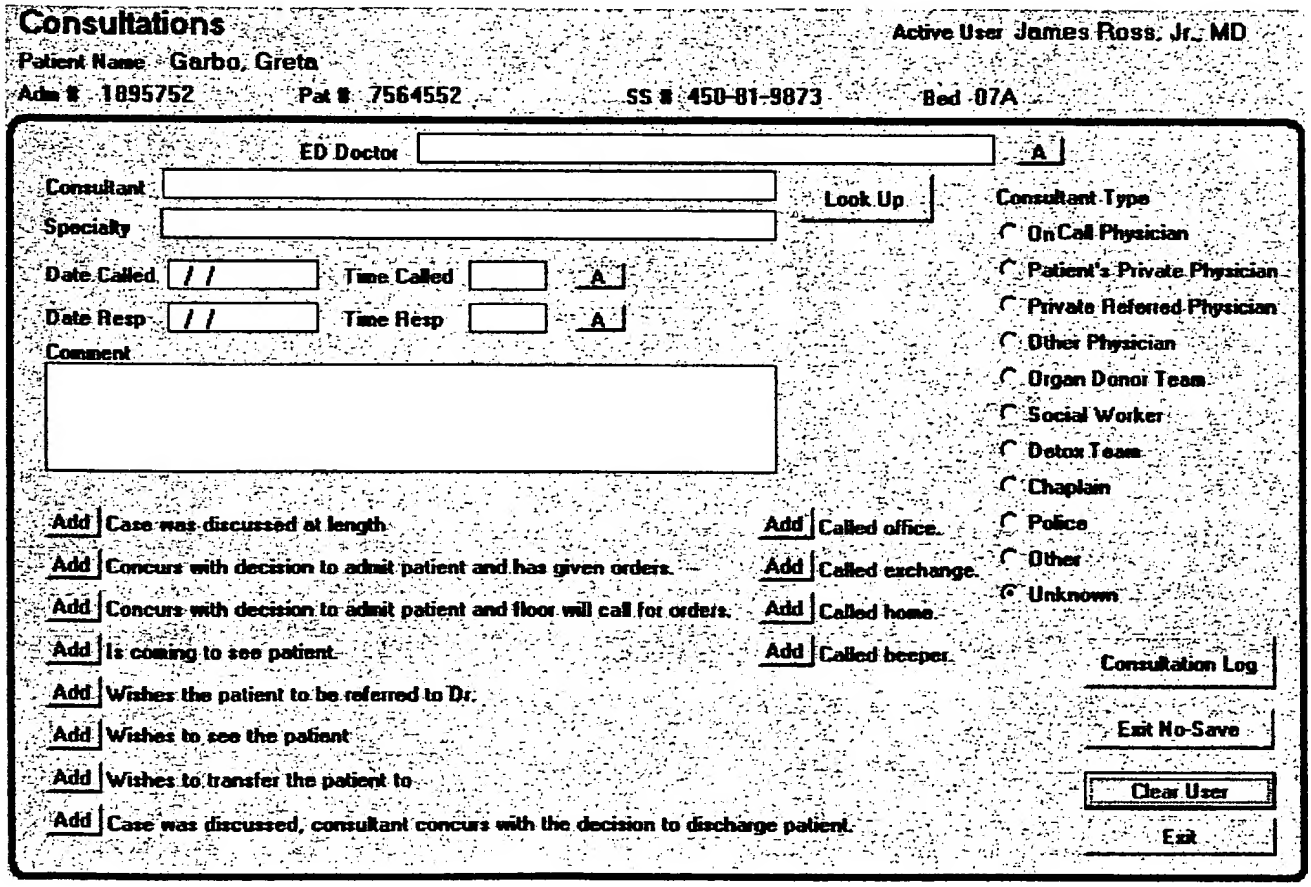


Figure Chapter 3: -121: Consultations

(Image: consultations.bmp)

Entering/Documenting Consultations (std. menu) *(continued)*

4a. Entering a new consultation:

- Select form fields and Add buttons as appropriate and complete.

- The Look Up button provides an updateable list of local "consultants".

4b. Update an existing consultation:

- Click on the Consultation Log button in the HISTORY section.

- Highlight the "consultant" name.
- Click the Edit button and update the form fields as required.

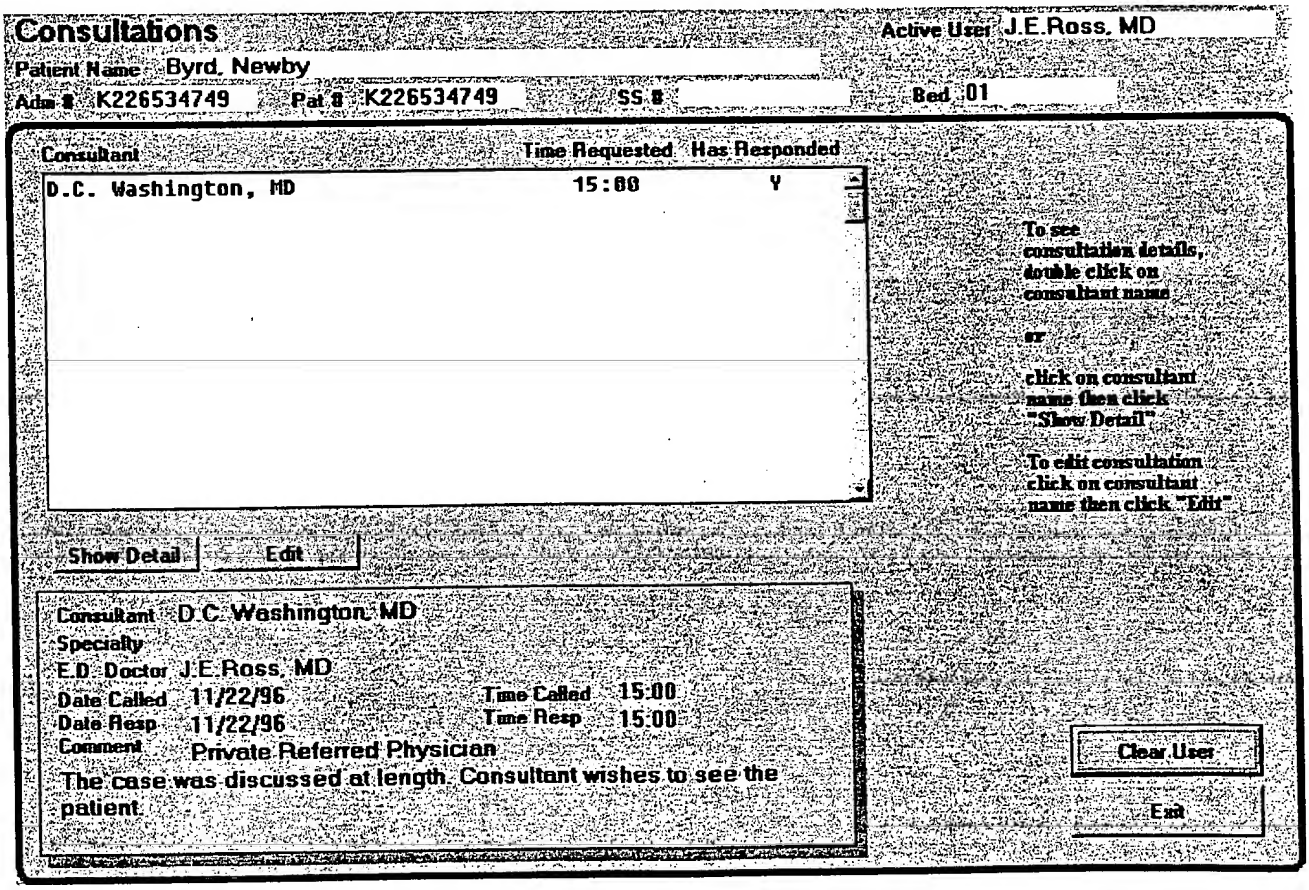


Figure Chapter 3: -122: Consultation Log

(Image: consultation-log.bmp)

5. Click the Exit button to save updated consultation information.

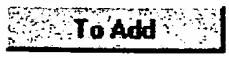
Entering/Updating Consultations Comments (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Transcript Editor button in the HISTORICAL section.



4a) Entering a new Consultations comment entry:

- Click on To Add button.
- Open the pull down menu and select "Consultations".

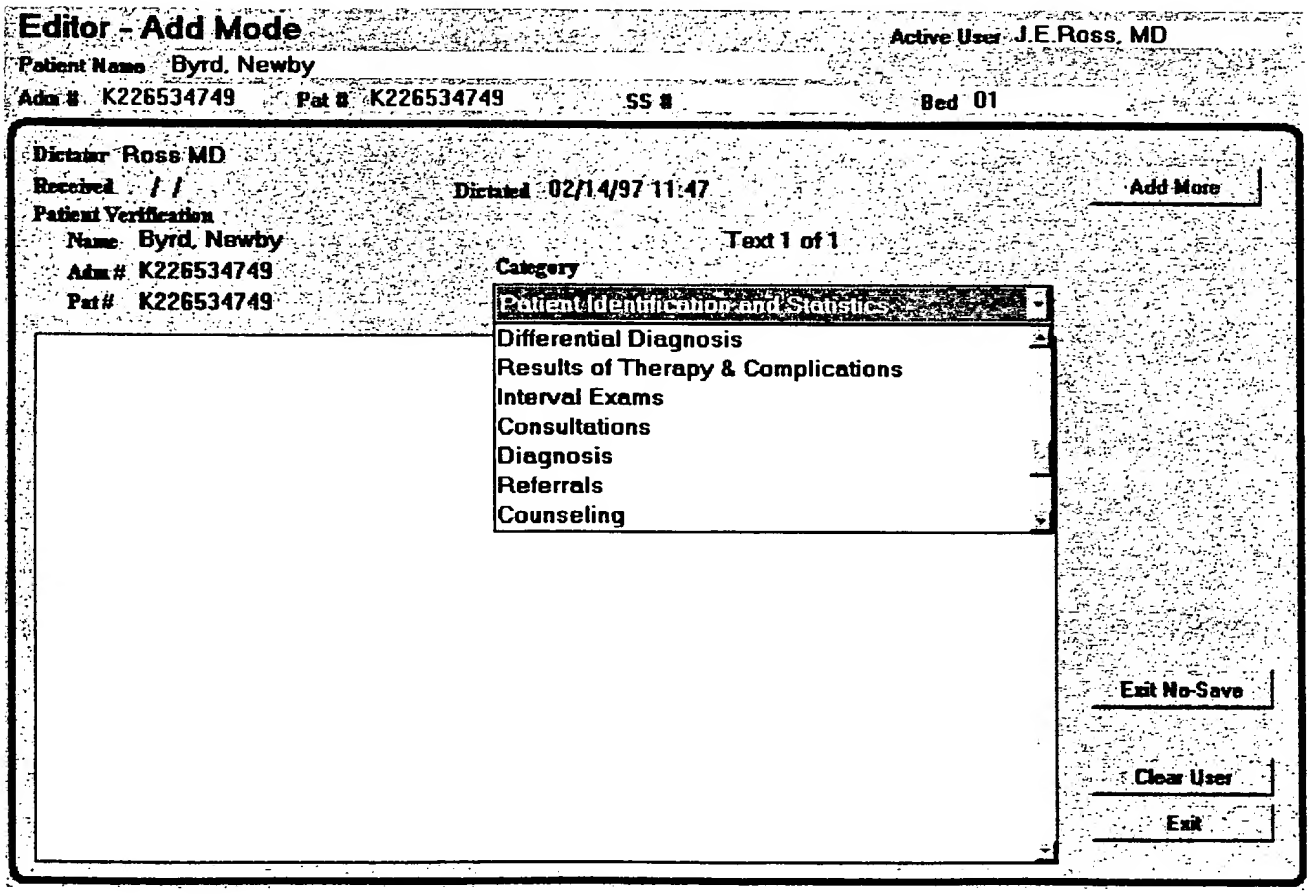


Figure Chapter 3: -123: Consultations (in Editor Add Mode)

(Image: editor-add-mode-4.bmp)

Entering/Modifying Consultations Comments (manual) *(continued)*

4b. Modify an existing Consultations comment entry:

- Click on Next / Prior (or First / Last) buttons to locate Consultations.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

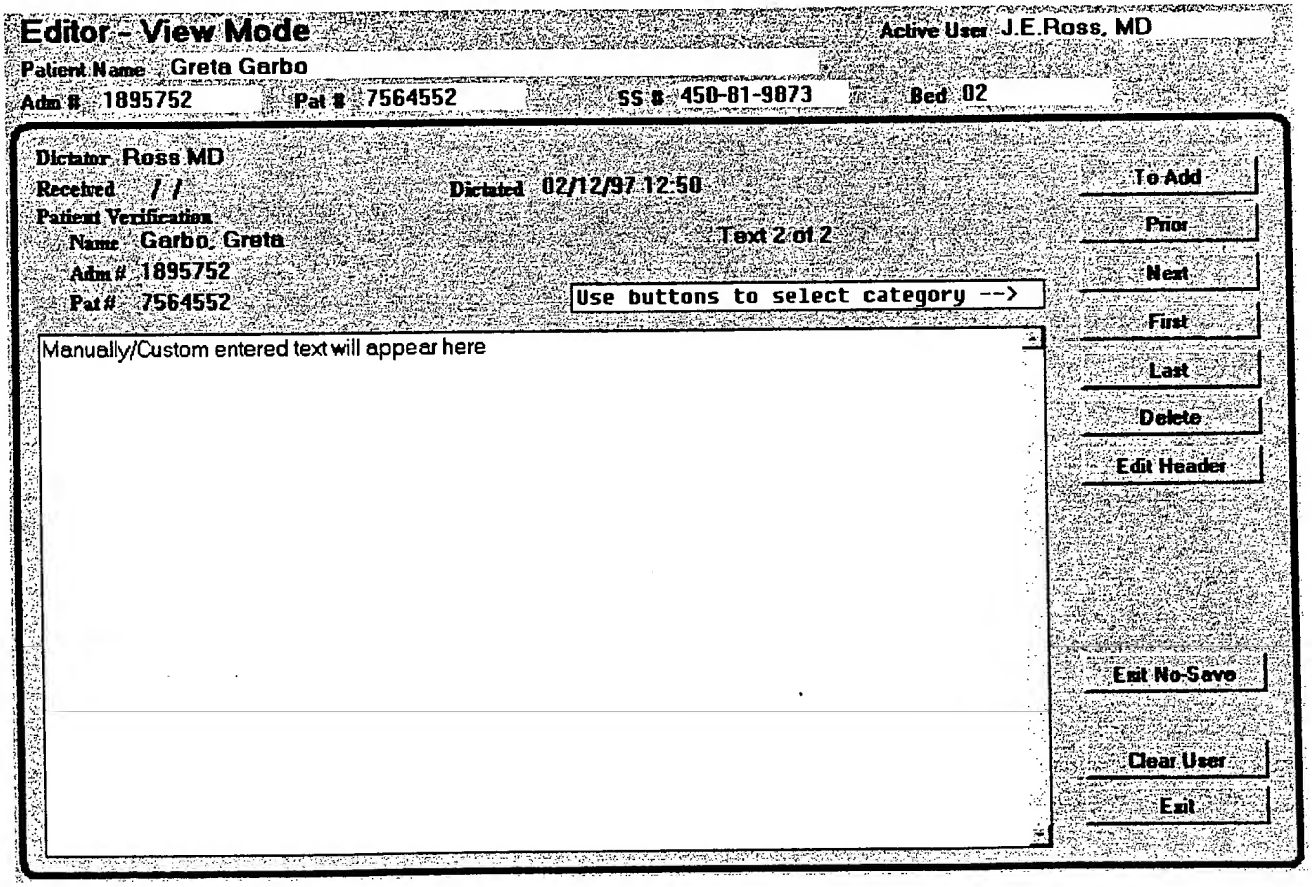


Figure Chapter 3: -124: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

6. Click the Exit button to save updated patient information.

Viewing Consultations *(continued)*

→ **Option C**

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Summary button in the HISTORICAL section. [brings you to the Medical Record Summary]

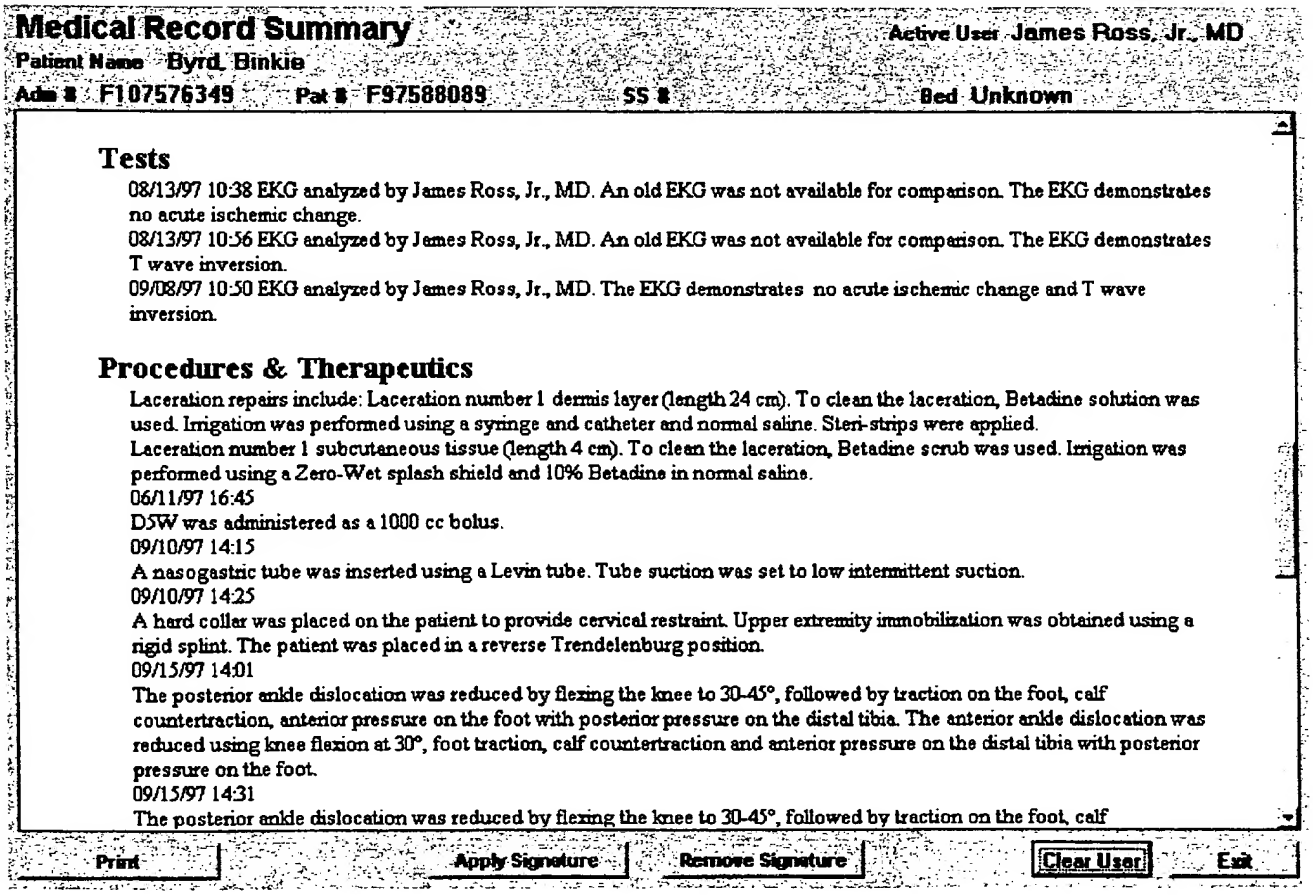


Figure Chapter 3: -127: Medical Record Summary

(Image: medical-record-summary-3.bmp)

4. Click the Scroll Bar to view additional information.

5. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Consultation

- The **Prephrased Text** function (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Consultations (comments, not requests) text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.

Viewing Physician/Patient Encounters Log

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click the Dr. Interval button in the HISTORICAL section.

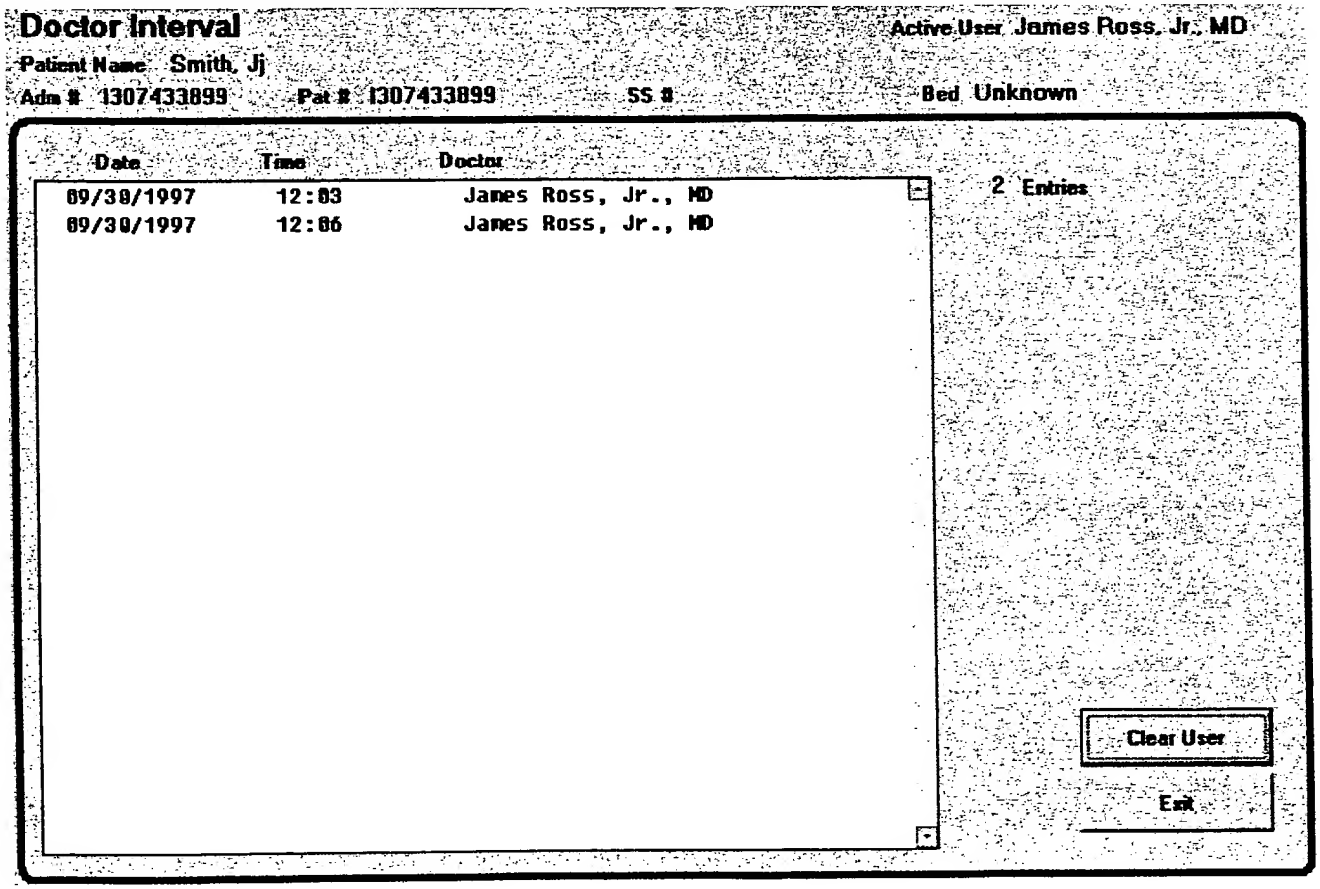


Figure Chapter 3: -131: Doctor Interval

(Image: doctor-interval.bmp)

5. Click the Exit button to save updated patient information.

Tips and Hints: Logging Physician/Patient Encounters & Interval Exams

- The **Prephrased Text** function (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Interval Exams comment text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.

Entering/Updating Prescriptions Comments (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Transcript Editor button in the HISTORICAL section.

4a) Entering a new Prescriptions comment entry:

- Click on To Add button.
- Open the pull down menu and select "Prescriptions".

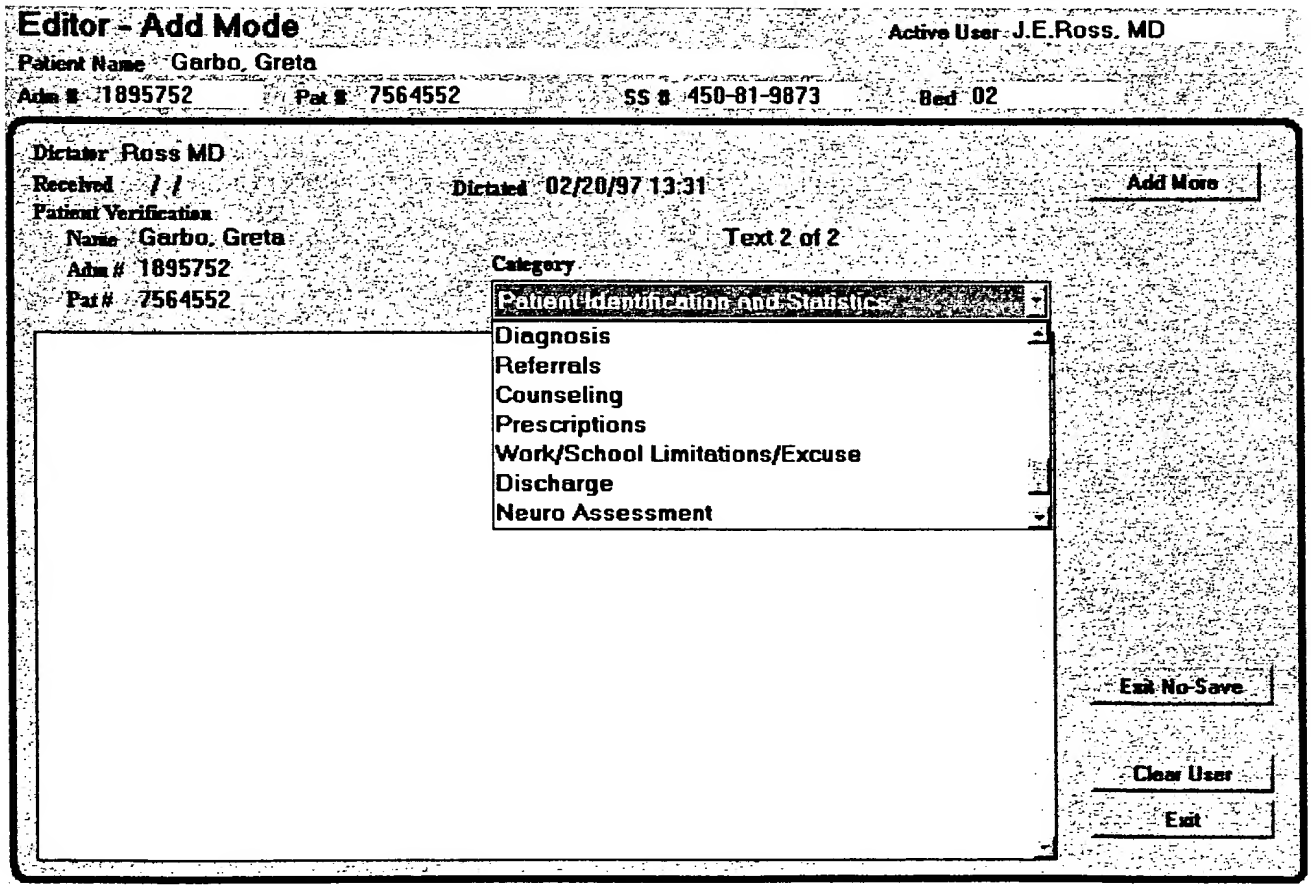


Figure Chapter 3: -134: Prescriptions (in Editor Add Mode)

(Image: editor-add-mode-6.bmp)

Entering/Modifying Prescriptions Comments (manual) *(continued)*

4b. Modify an existing Prescriptions comment entry:

- Click on Next / Prior (or First / Last) buttons to locate Prescriptions.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

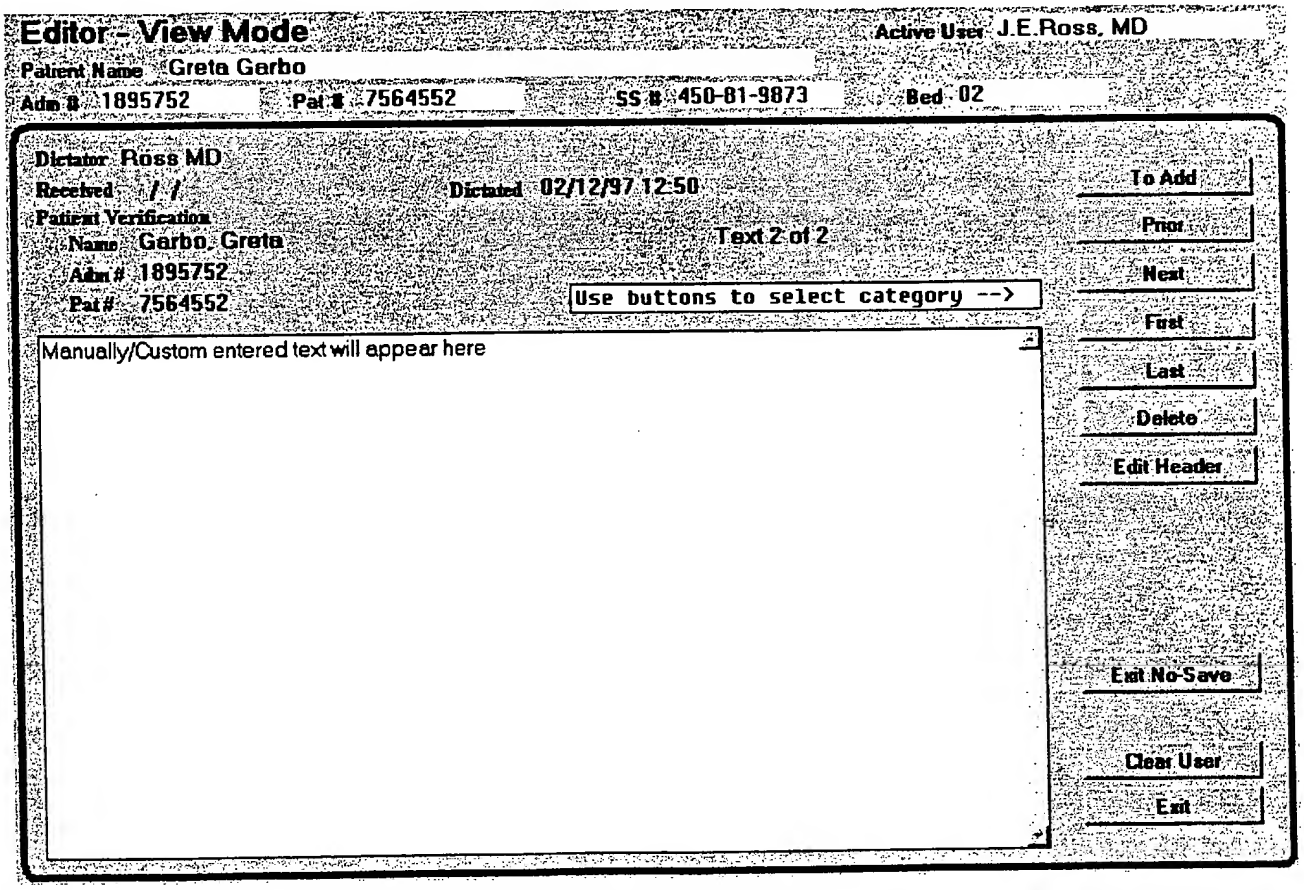


Figure Chapter 3: -135: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

6. Click the Exit button to save updated patient information.

Viewing Prescribed Medications

→ Option A

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on Prescribed Meds button in HISTORICAL section.

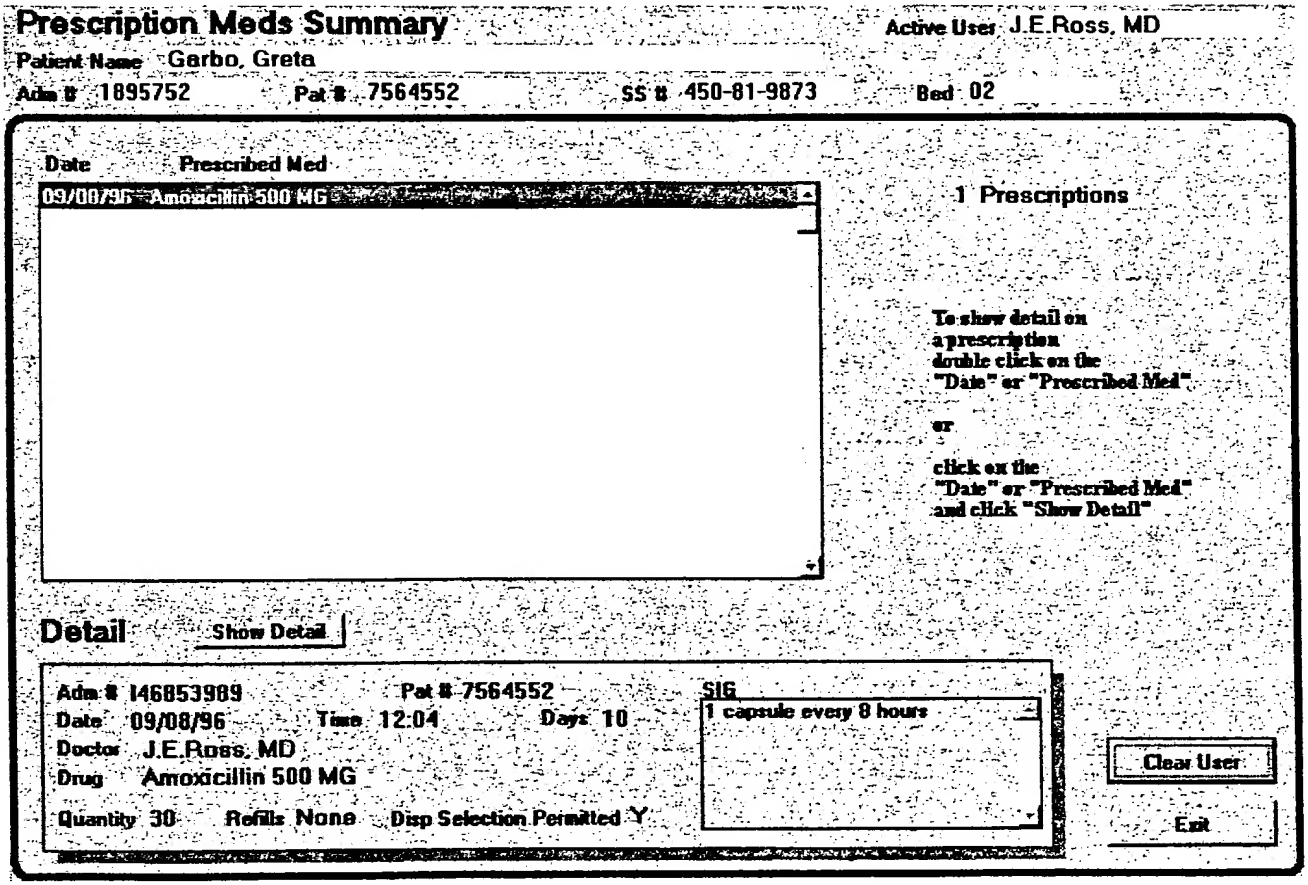


Figure Chapter 3: -136: Prescription Meds Summary

(Image: prescription-meds-summary.bmp)

4. Click (highlight) one of the drugs listed.

5. Click on the Show Detail button.

6. Click the Exit button to save updated patient information.

View Prescribed Medications *(continued)*

→ **Option B**

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Summary button in the HISTORICAL section. [brings you to the Medical Record Summary]

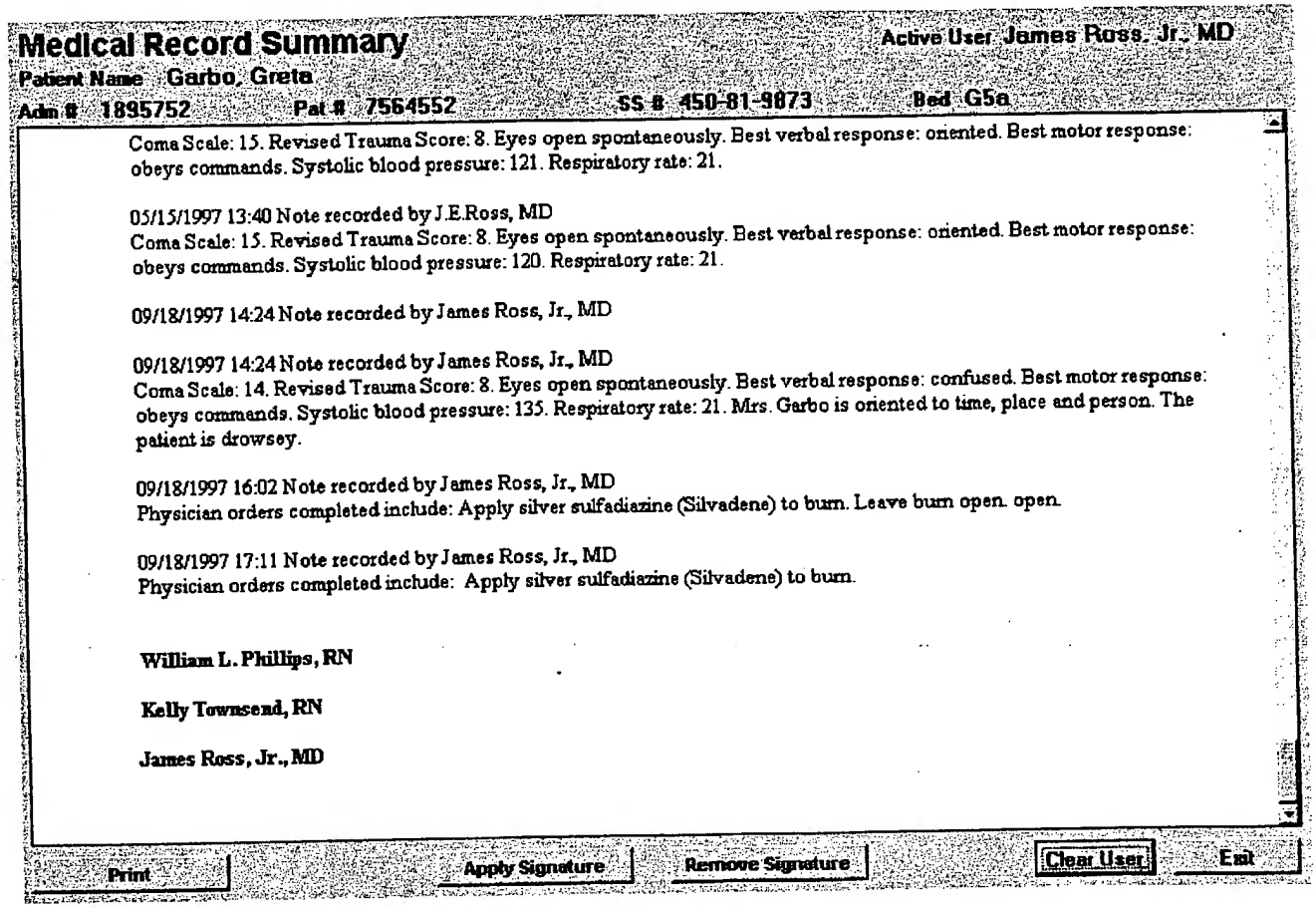


Figure Chapter 3: -137: Medical Record Summary

(Image: medical-record-summary-6.bmp)

4. Click the Scroll Bar to view additional information.

5. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Writing Prescriptions

- The **Prephrased Text** function (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Prescription comments text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.

Patient Instruction Sets

Queuing Patient Instruction Sets

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Patient Instructions button at the right of screen.

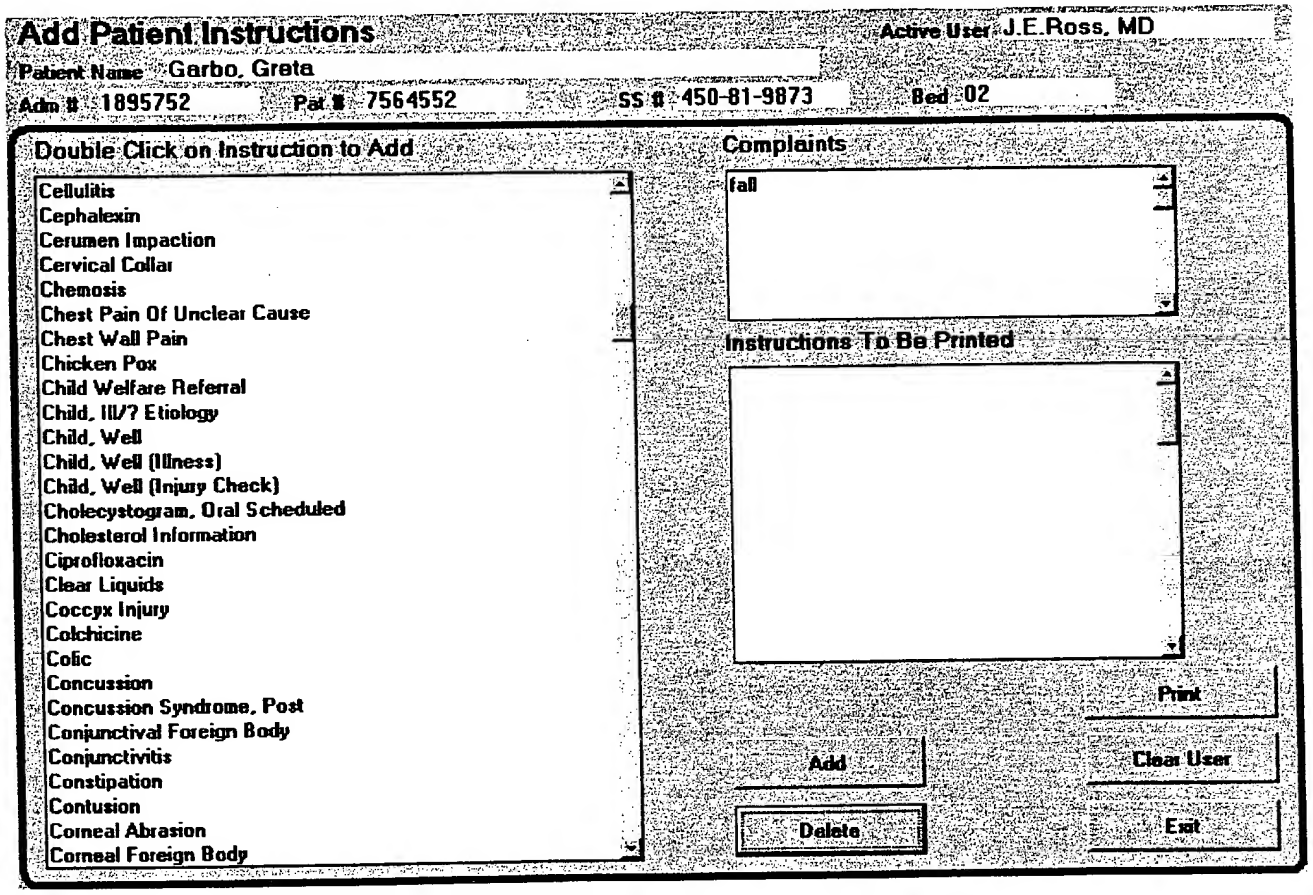
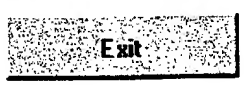


Figure Chapter 3: -138: Add Patient Instructions

(Image: add-patient-instructions.bmp)

or

4. Select (click on) the appropriate instruction(s) from the instructions menu and click on the Add button to place the instruction(s) into the "Instructions to be printed" queue. To remove instruction(s) from the queue, select the instruction(s) then click on the Delete button.



5. Click the Exit button to return to the Medical Information screen.

Work Excuses/School Excuses

Writing a Work Excuse

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Work Excuse

3. Click on the Work Excuse button at the right of screen.

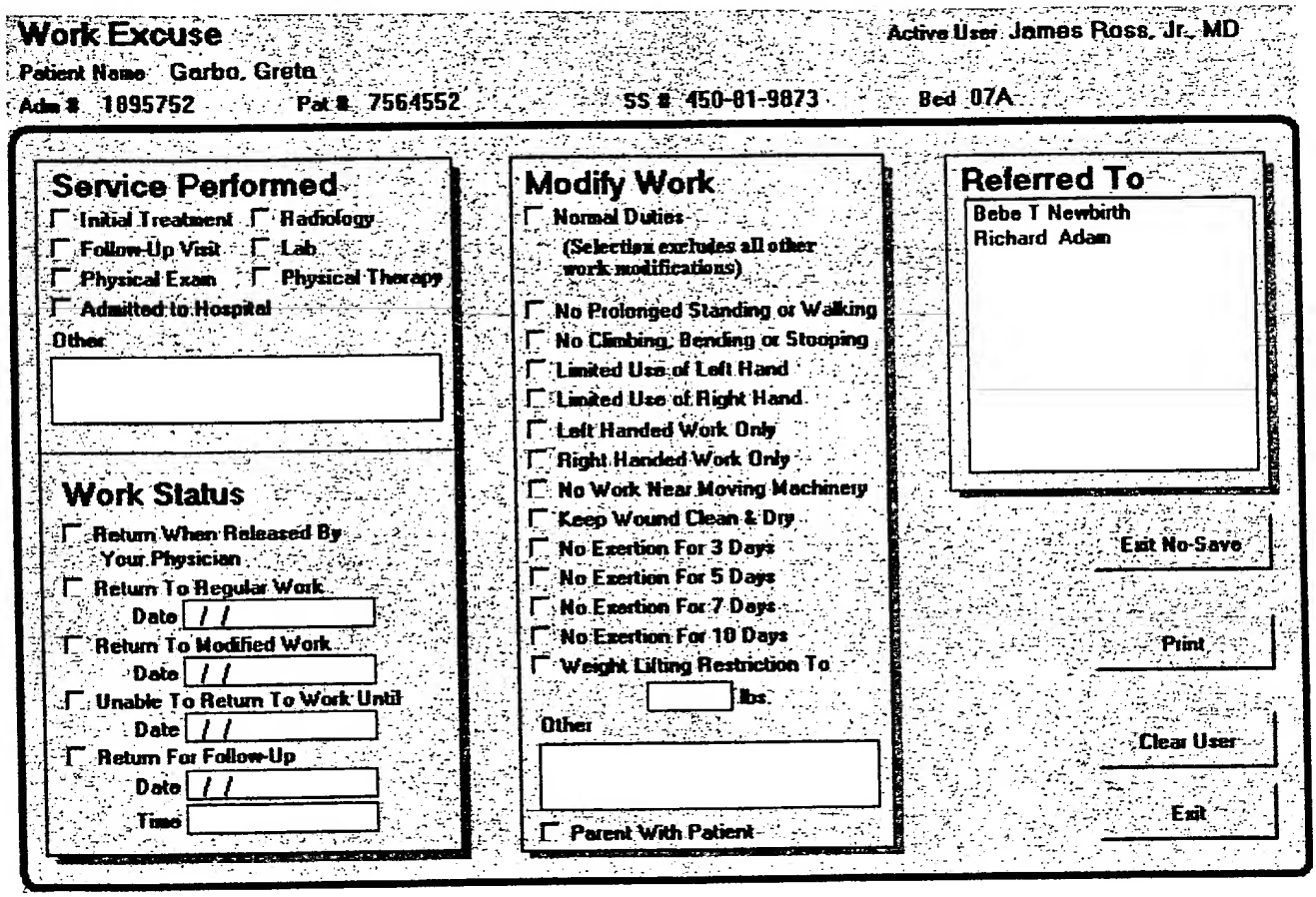


Figure Chapter 3: -139: Work Excuse

(Image: work-excuse.bmp)

4. Click on check boxes and form fields to complete as appropriate.

Exit

5. Click the Exit button to save updated patient information.

Writing a School Excuse

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the School Excuse button at the right of screen.

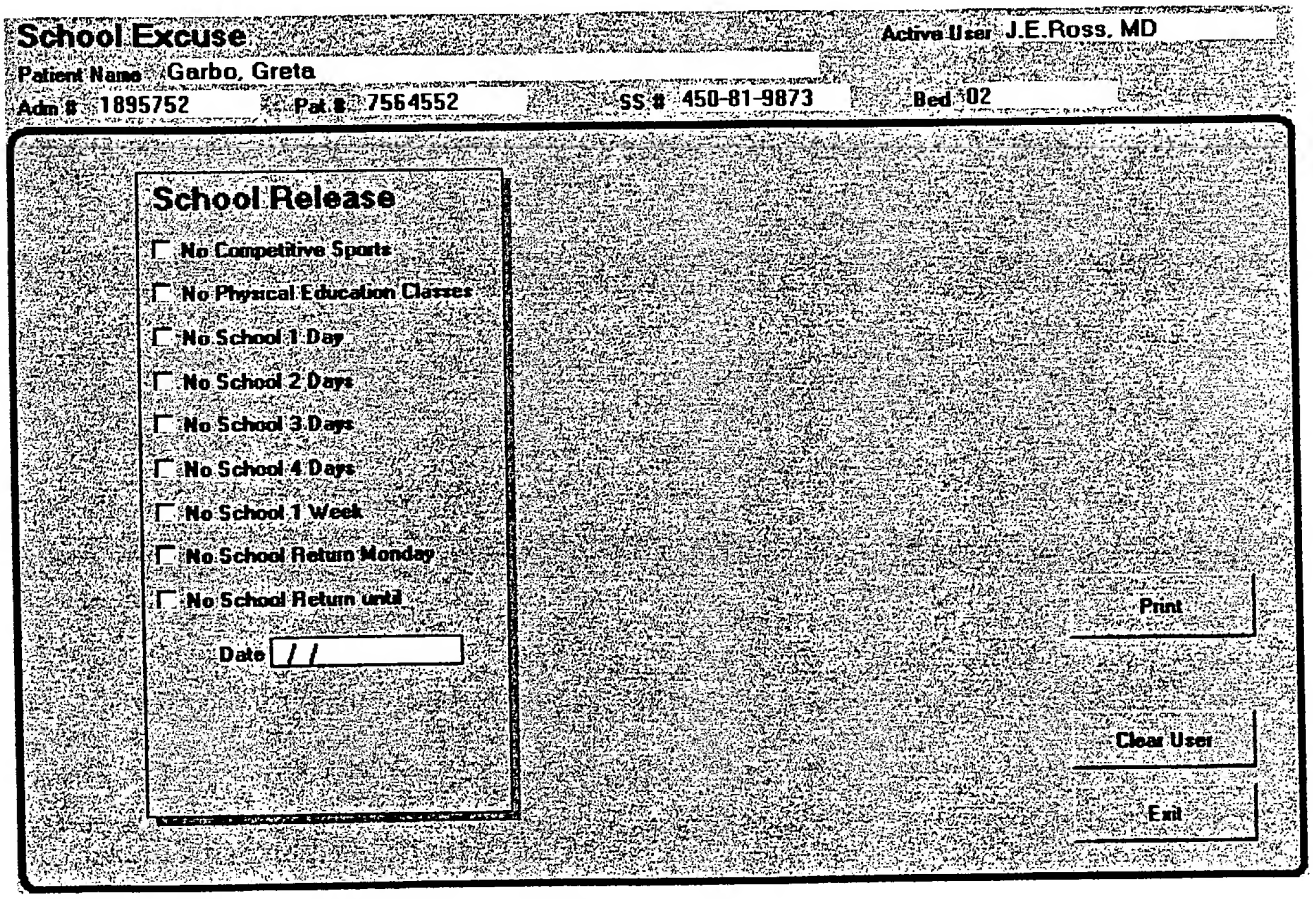


Figure Chapter 3: -140: School Excuse

(Image: school-excuse.bmp)

4. Click on check boxes and form fields to complete as appropriate.

5. Click the Exit button to save updated patient information.

Entering/Updating Work/School Limitations/Excuse Comments (manual)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Transcript Editor

3. Click on the Transcript Editor button in the HISTORICAL section.

To Add

4a) Entering a new Work/School Limitations/Excuse comment entry:

- Click on To Add button.
- Open the pull down menu and select "Work/School Limitations/Excuse."

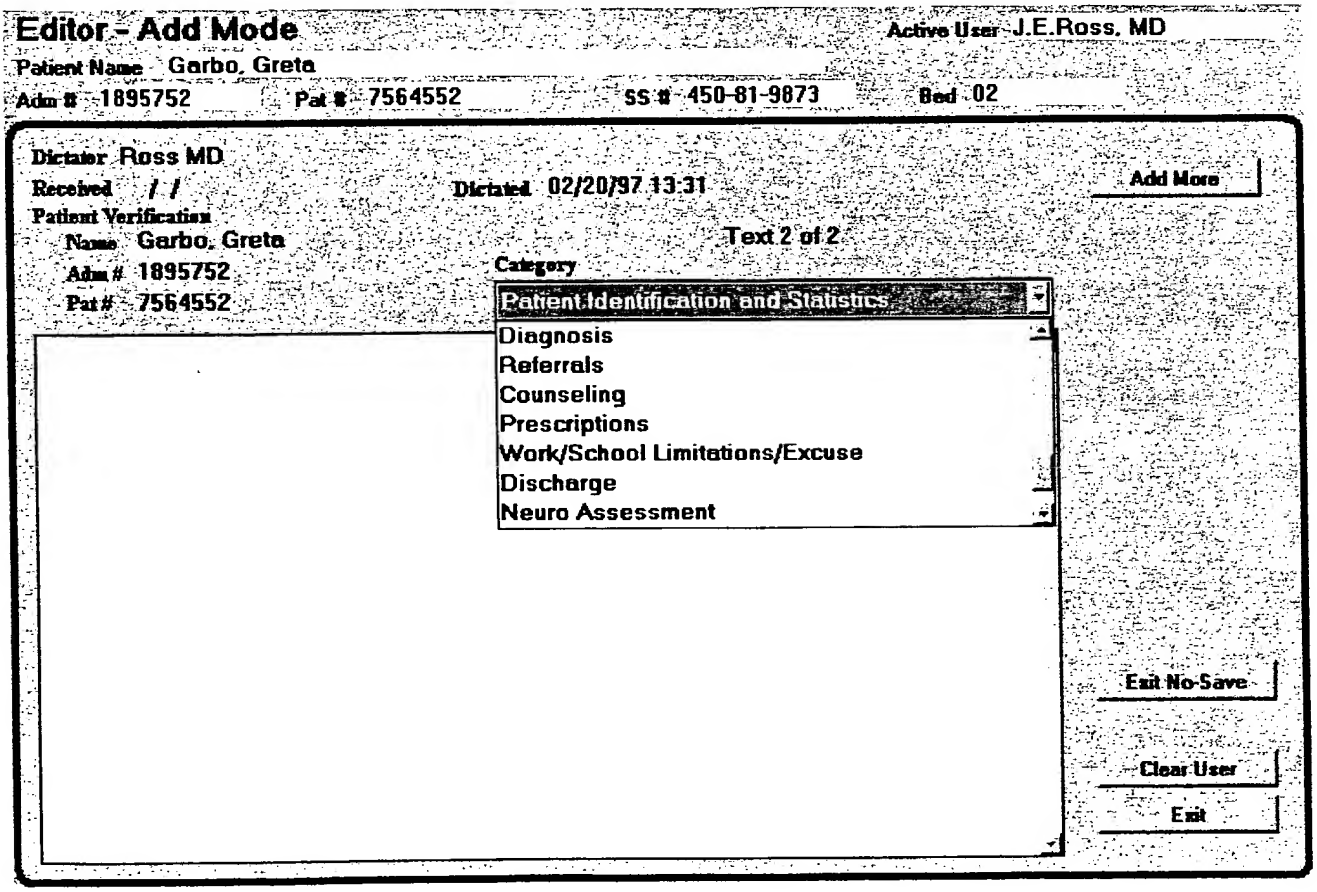


Figure Chapter 3: -141: Work/School Limitations/Excuse (in Editor Add Mode)

(Image: editor-add-mode-6.bmp)

Entering/Modifying Work/School Limitations/Excuse Comments (manual) *(cont.)*

4b. Modify an existing Work/School Limitations/Excuse comment entry:

- Click on Next / Prior (or First / Last) buttons to locate Work/School Limitations/Excuse.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

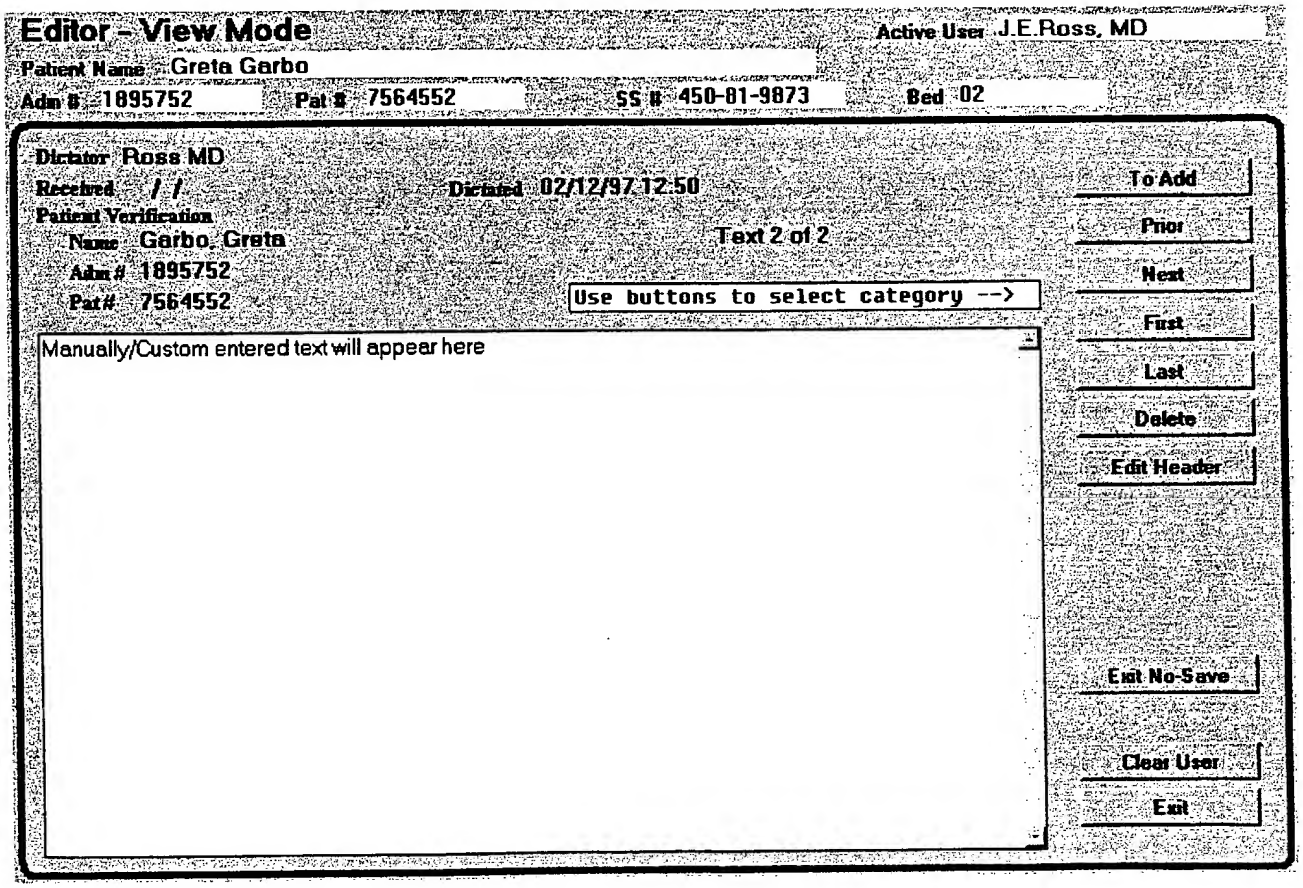


Figure Chapter 3: -142: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

6. Click the Exit button to save updated patient information.

Tips and Hints: Work/School Limitations/Excuse

- The **Prephrased Text** function (accessed from the Medical Information screen) provides an alternative means of entering customized, menu based Work/School Limitations/Excuse comments text into the Medical Record. Go to page 78, "Prephrased Text for the Medical Record", for more information on the use of Prephrased Text.

Printing Prescriptions, Patient Instructions & Excuses

Printing Prescriptions

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Prescriptions button in the INPUT section.

4. Double Click on one of the drugs initially listed (your customized drug listing).

Refer to "Writing Prescriptions (std. menu)," *page 200, for expanded graphics.*

5. Click on the appropriate buttons to select prescription: No. (dosage), Type, route, Frequency, Duration. Note the check boxes: +1/2, As Needed, Refills PRN, Selection Permitted and Dispense As Written.

6. Click the Print button.

Printing Patient Instruction Sets

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Patient Instructions button at the right of screen.

or

4. Select (click on) the appropriate instruction(s) from the instructions menu and click on the Add button to place the instruction(s) into the "Instructions to be printed" queue. To remove instruction(s) from the queue, select the instruction(s) and click on the Delete button.

Refer to "Queuing Patient Instruction Sets," page 207 for expanded graphics.

5. Click on the Print button to print Patient Instructions

Printing a Work Excuse

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Work Excuse button at the right of screen.

4. Click on check boxes and form fields to complete as appropriate.

Refer to "Writing a Work Excuse," *page 208, for expanded graphics.*

5. Click on the Print button to print a Work Excuse.

Printing a School Excuse

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the School Excuse button at the right of screen.

4. Click on check boxes and form fields to complete as appropriate.

fer to "

Writing a School Excuse," *page 209, for expanded graphics.*

5. Click on the Print button to print a School Excuse.

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Dictation Review and Modification

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Transcript Editor button in the HISTORICAL section.

4a) Entering a new Dictation entry:

- Click on To Add button.
- Open the pull down menu and select a Category.

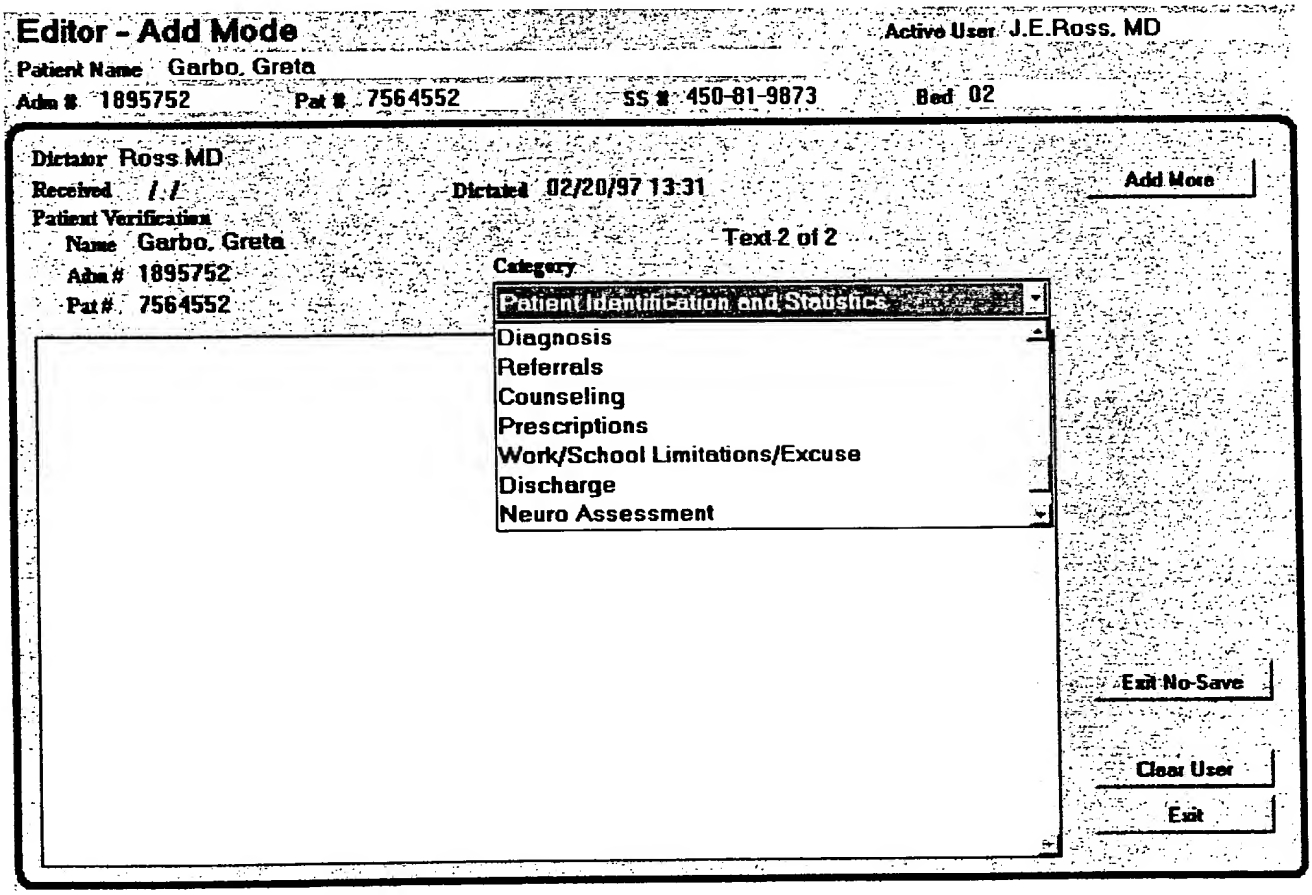


Figure Chapter 3: -143: Adding Dictation (Editor Add Mode)

(Image: editor-add-mode-6.bmp)

Dictation Review and Modification *(continued)*

4b. Modify an existing Dictation entry:

- Click on Next / Prior (or First / Last) buttons to locate Category.

5. Click on the multiline form field to manually add or modify any text, or, click on the Delete button to remove the selected entry.

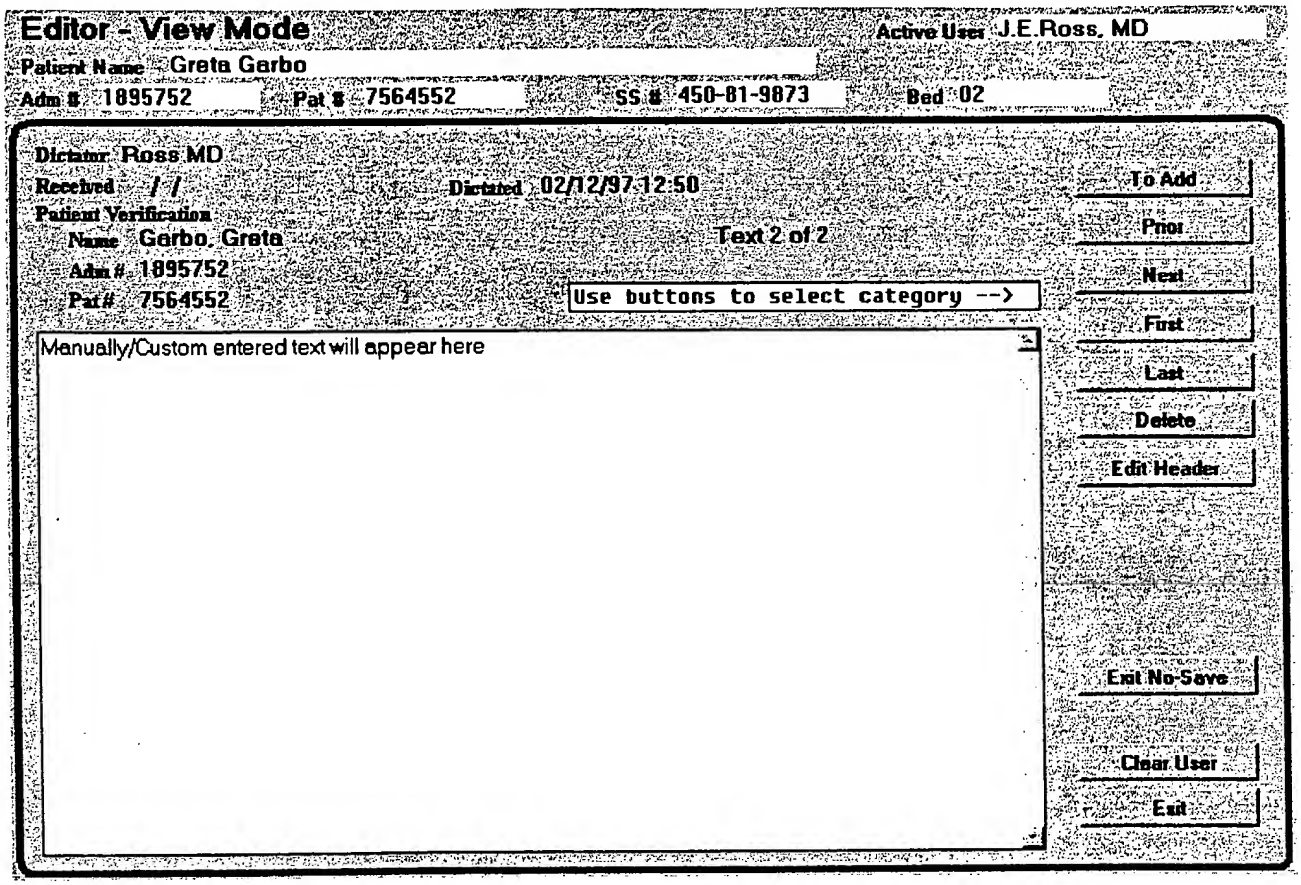


Figure Chapter 3: -144: Editing Manual/Custom Medical Record

(Image: editor-view-mode-generic.bmp)

6. Click the Exit button to save updated patient information.

Transcription and Record Review/Approval

Medical Record Summary Review

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Summary

3. Click on the Summary button in the HISTORICAL section. [brings you to the Medical Record Summary]

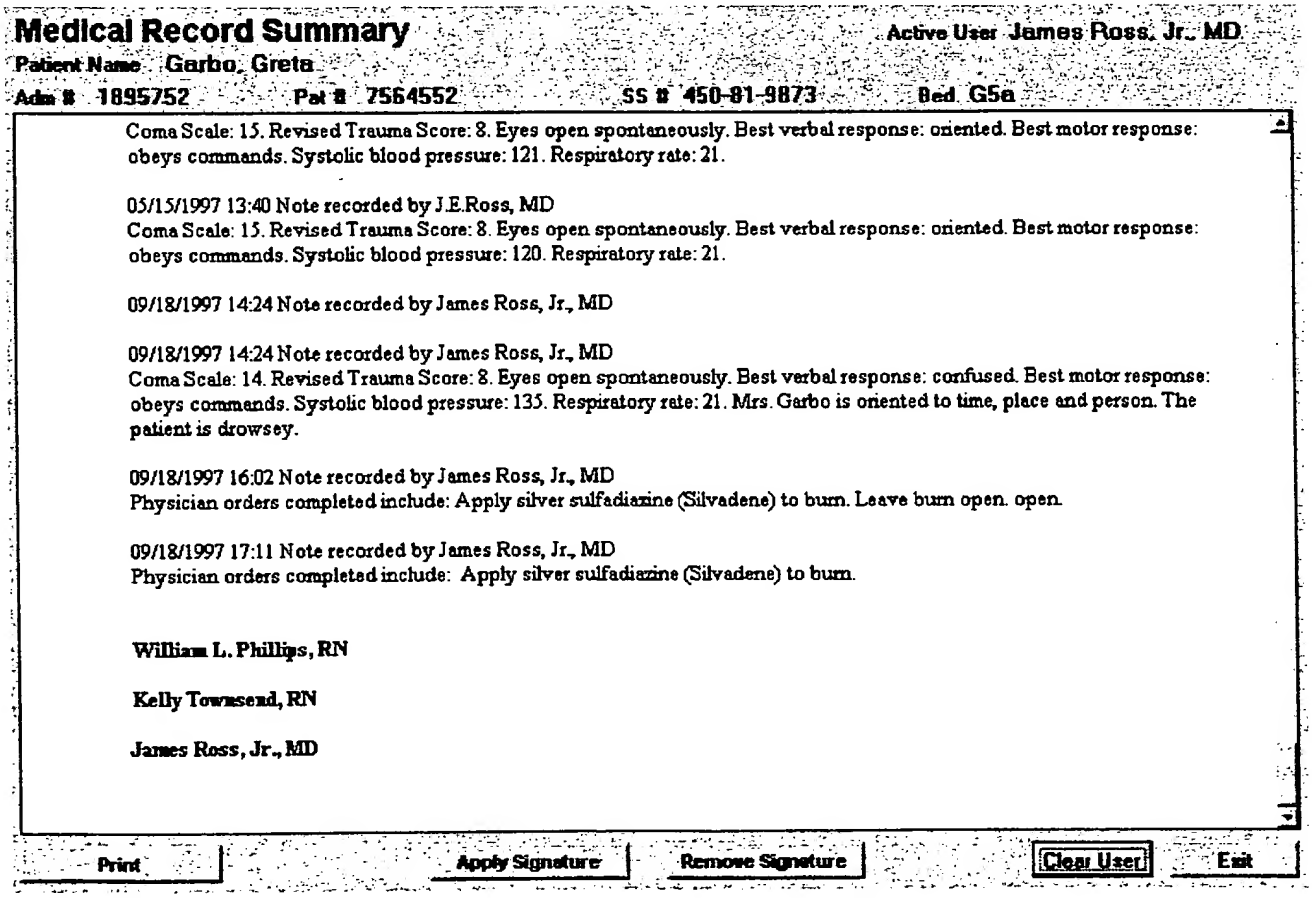


Figure Chapter 3: -145: Medical Record Summary

(Image: medical-record-summary-7.bmp)

4. Click the Scroll Bar to review information.

Exit

5. Click the Exit button to return to the Medical Information screen.

Physician Medical Record Electronic Signatures

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Summary button in the HISTORICAL section. [brings you to the Medical Record Summary]

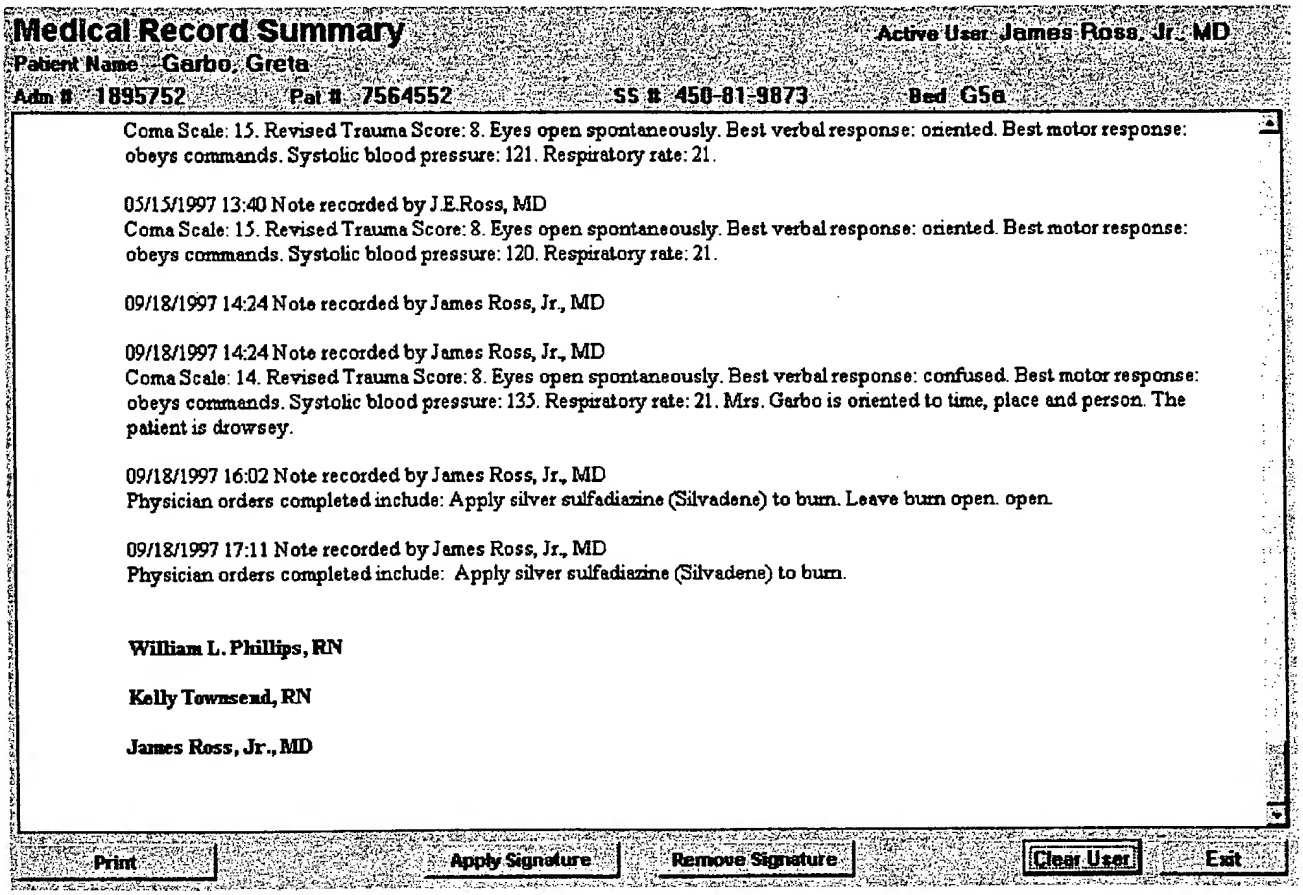


Figure Chapter 3: -146: Medical Record Summary

(Image: medical-record-summary-7.bmp)

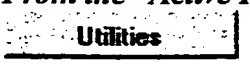
4. Click on Apply or Remove Signature buttons as required.
5. Click the Exit button to return to the Medical Information screen.

TeleMed Transcript Locator

Use this utility to locate and correct transcripts sent with incorrect admission number or record component type.

Locating/Viewing/Correcting Transcript

From the "Active Patient List" (your main tracking screen)



1. Click the Utilities button.

2. Click on the Transcript Locator button at the right of screen.
3. Enter the Target Admission #
   - If you are not sure of the Admission #, click on the Communication Log button to locate it.

4. Click on the Find button.

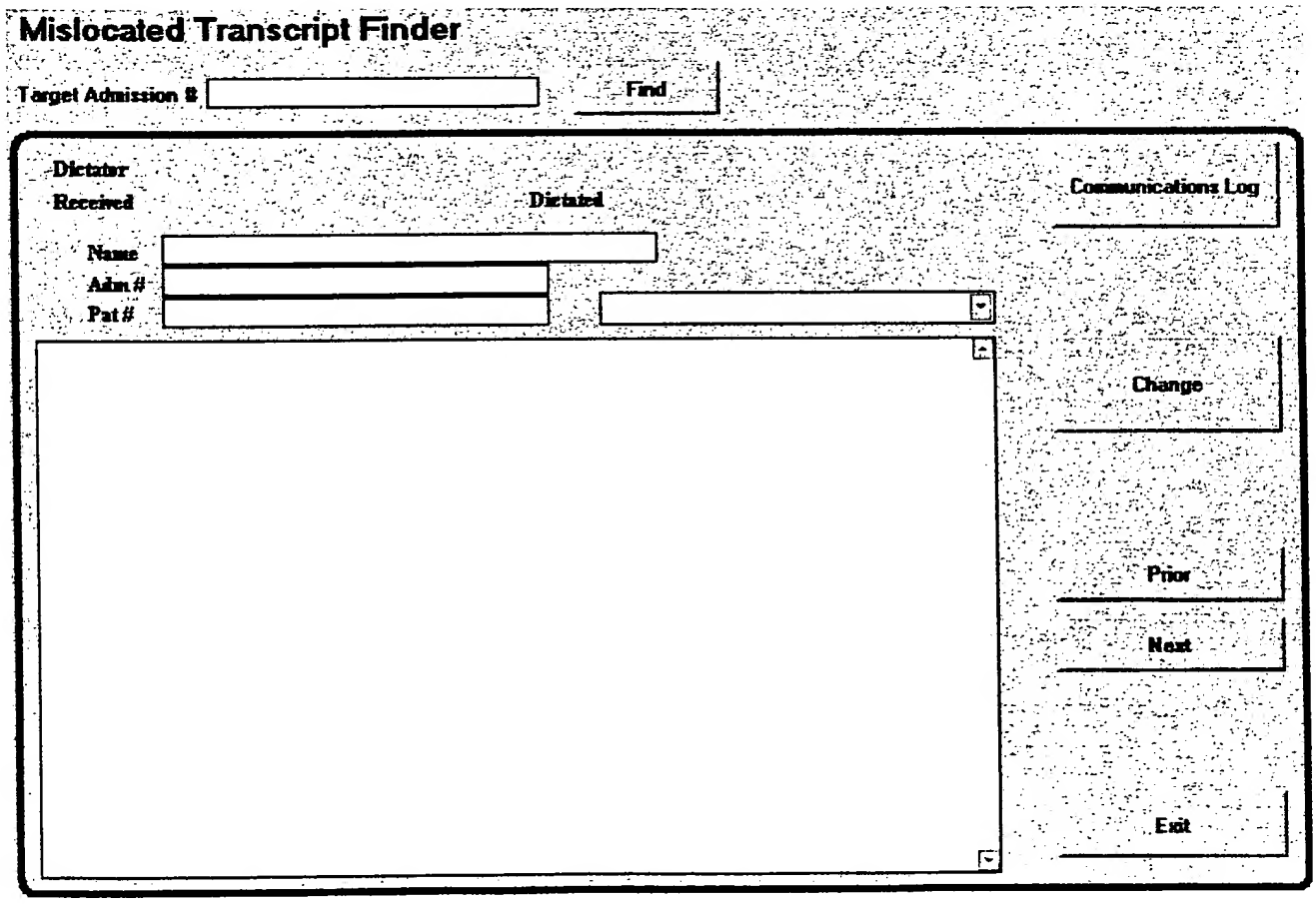
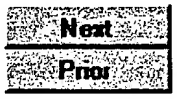


Figure Chapter 3: -147: Mislocated Transcript Finder

(Image: mislocated-transcript-finder.bmp)

Locating/Viewing/Correcting Transcript *(continued)*



5. Click on the Next / Prior button to locate the transcript component.
6. Correct admission number or record component type as appropriate.

7. Click on the Change button.

Tips and Hints: Transcript Locator

- Each block is designated to appear in a separate component of the medical record as noted by the pull down field.
- If the Adm. No. was in error, the number must be changed on each block, and Change selected to save the change.
- Any element displayed in yellow can be changed.

- Note: the primary function of this utility is to locate transcriptions which did not attach to the appropriate medical record. The system uses the admission number as the link. If the admission number is not correct when sent from the dictation company or department, the system will not attach the blocks to the proper medical record. The other elements can be easily edited through the Transcript Editor button on the Medical Information screen.

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TeleMed Progress Notes Section

Vital Signs

Entering Vital Signs (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Vital Signs button in the INPUT section.

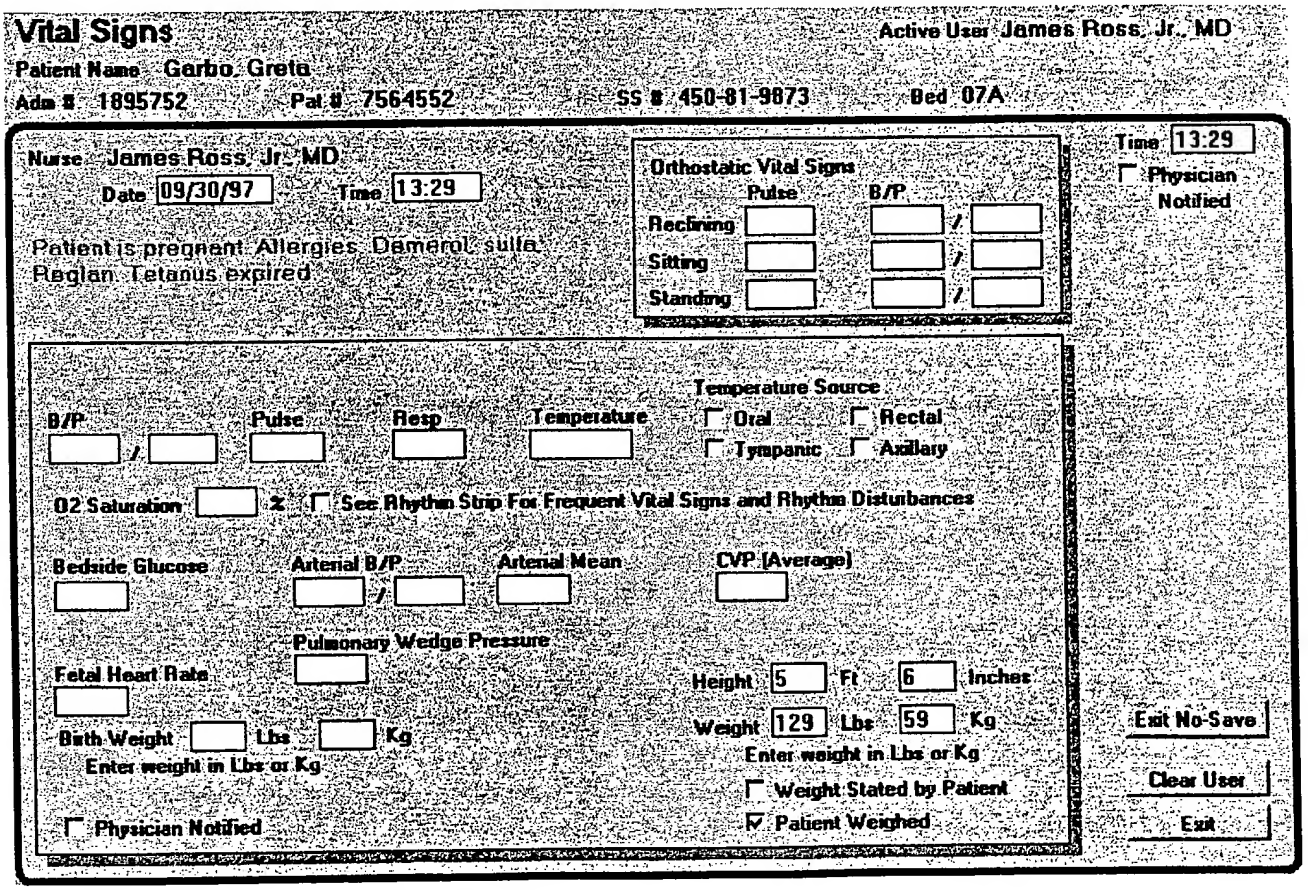


Figure Chapter 3: -148: Vital Signs

(Image: vital-signs.bmp)

4. Click on check boxes and form fields to complete as appropriate.

5. Click the Exit button to return to the Medical Information screen.

Viewing Vital Signs

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Vital Signs

3. Click on the Vital Signs button in the HISTORICAL section.

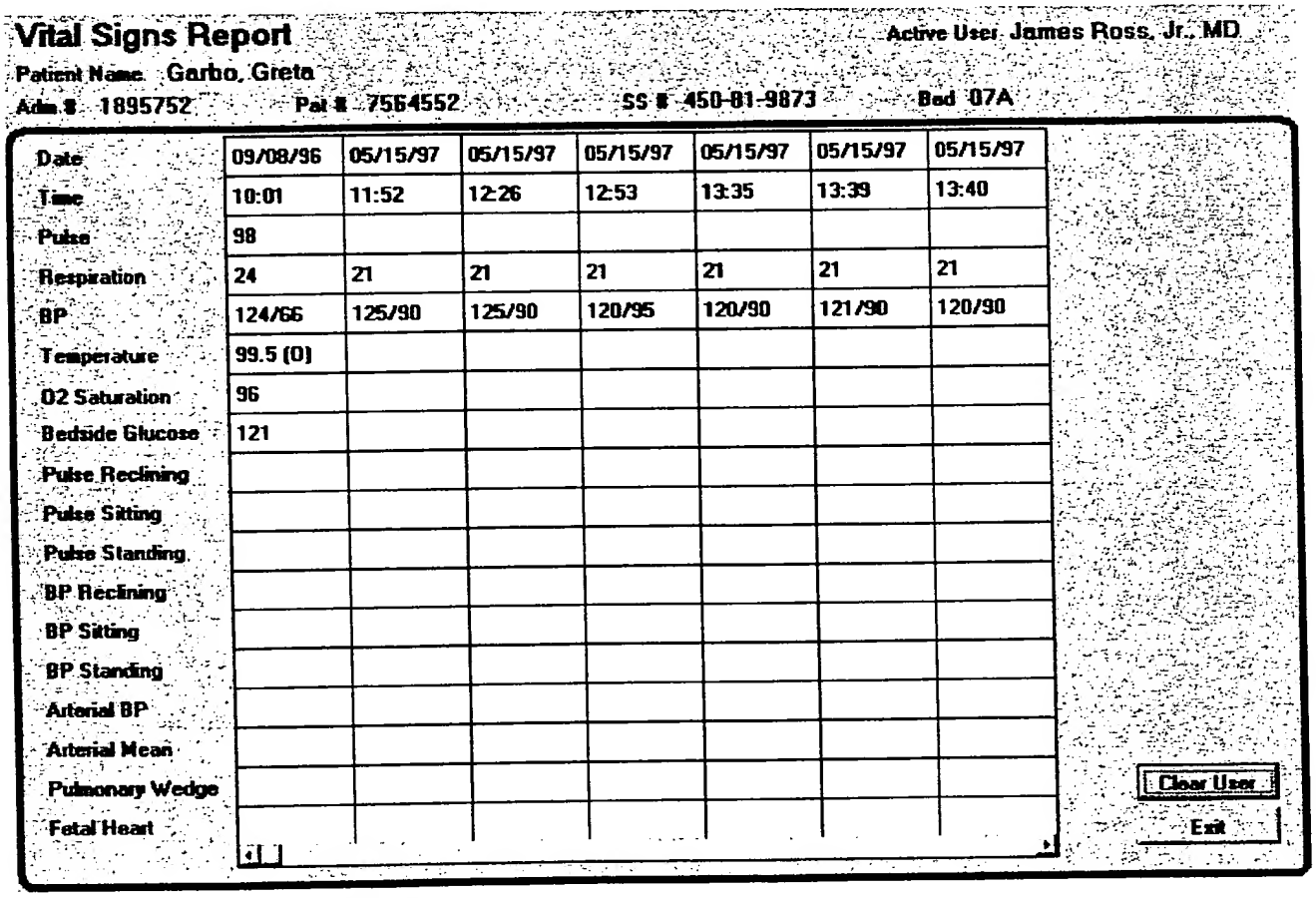


Figure Chapter 3: -149: Vital Signs Report
(Image: vital-signs-report.bmp)

Exit

7. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Vital Signs

- You can review the Vital Signs record by clicking on the Summary or Progress Notes Summary buttons in the HISTORICAL section.

Assessments

Entering Neurological Assessment (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Progress Notes

3. Click on the Progress Notes button in the INPUT section.

Assessment Neuro

4. Click on the Assessment Neuro button.

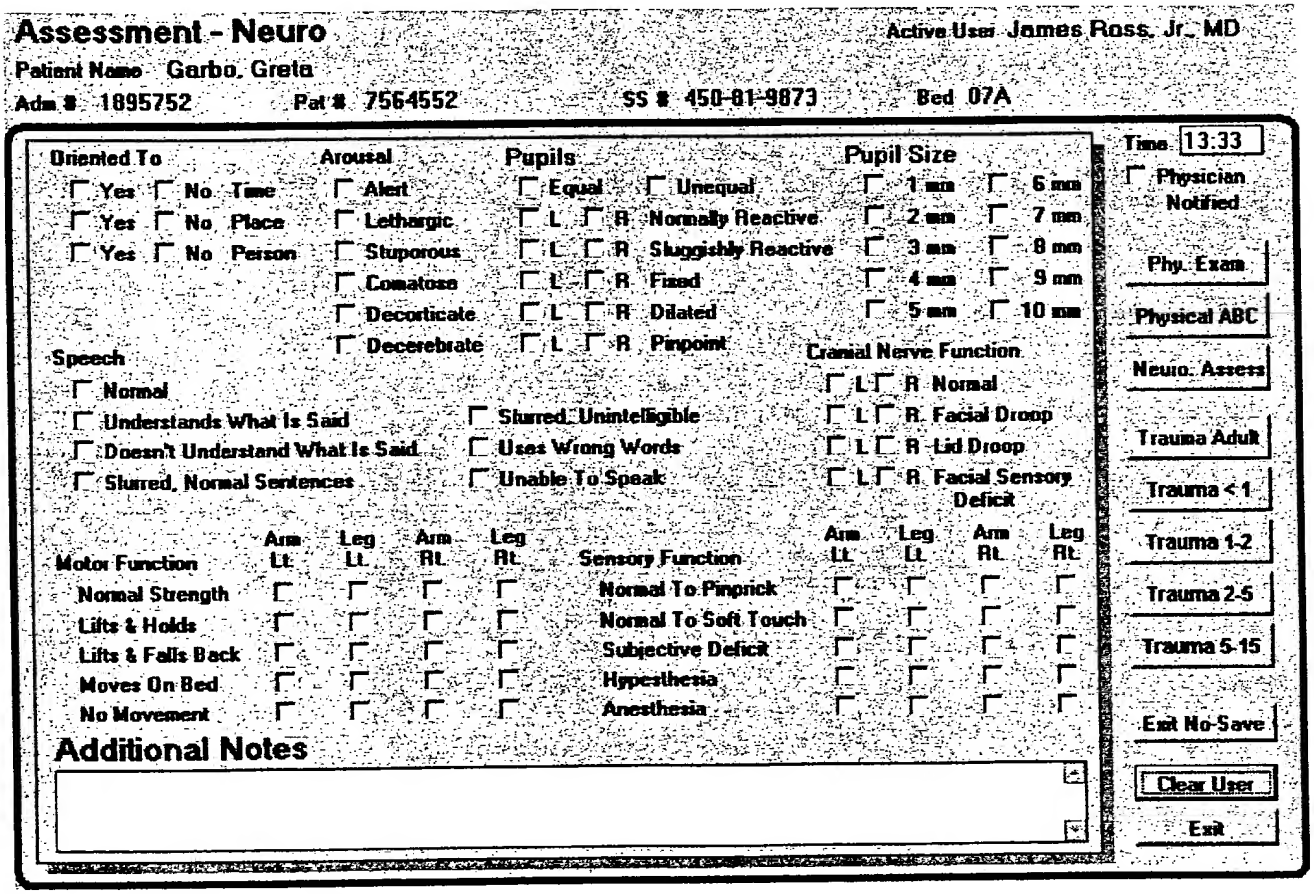


Figure Chapter 3: -150: Assessment - Neuro

(Image: assessment-neuro.bmp)

5. Enter (click on) all appropriate neurological conditions.

Exit

6. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Neurological Assessment

- You can review the Neurological Assessment record by clicking on the Summary or Progress Notes Summary buttons in the HISTORICAL section.
- ***Alternate access to this screen:***
  Assessment Physical - ABC
  Nursing Physical Exam
  All Truama screens

Entering Physical Exam (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Progress Notes button in the INPUT section.

4. Click on the (Nursing) Physical Exam button.

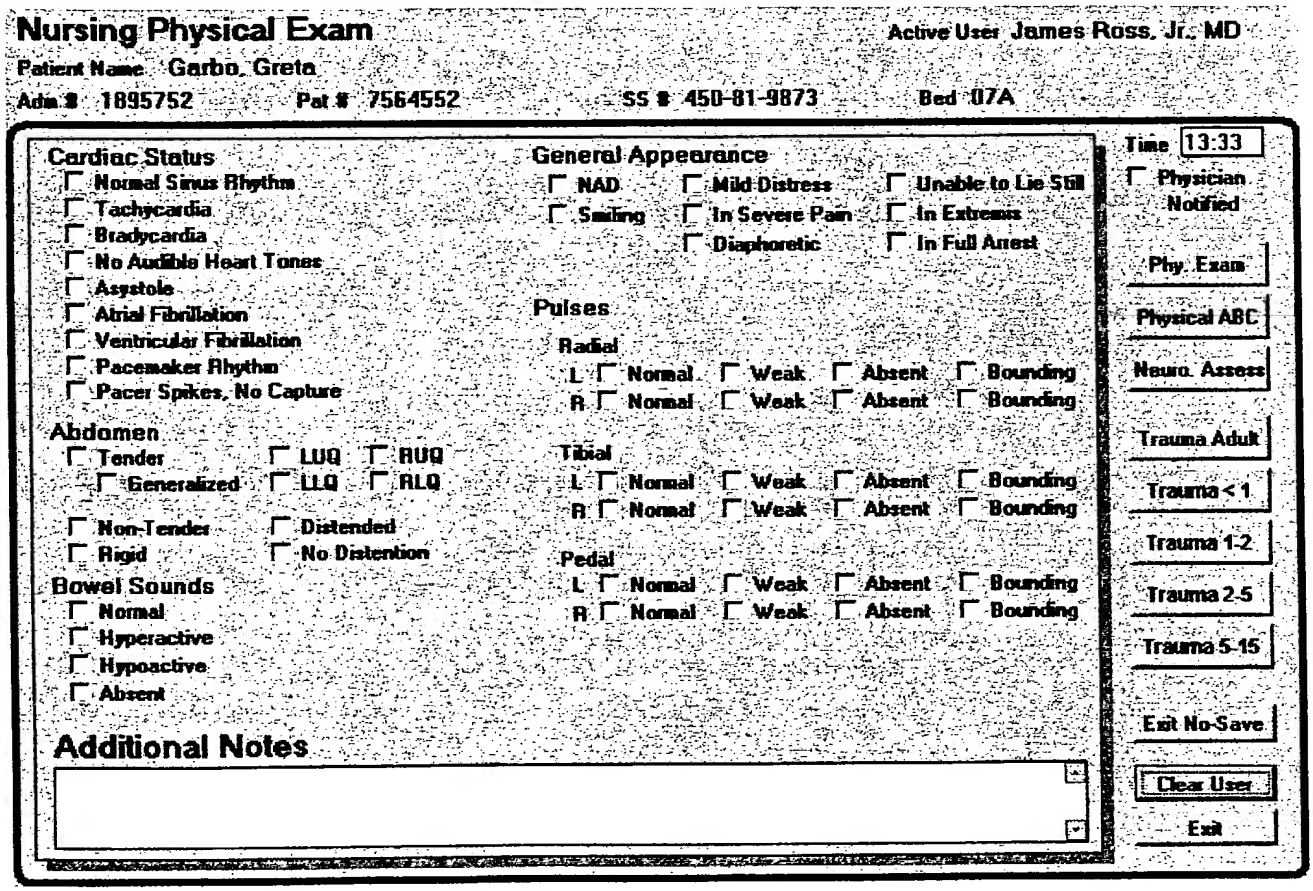
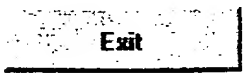


Figure Chapter 3: -151: Nursing Physical Exam

(Image: nursing-physical-exam.bmp)

5. Enter (click on) all appropriate physical conditions.



6. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Physical Exam

- You can review the Physical Exam record by clicking on the Summary or Progress Notes Summary buttons in the HISTORICAL section.
- ***Alternate access to this screen:***
  Assessment Physical - ABC
  Assessment - Neuro
  All Truama screens

Entering Physical ABC (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Progress Notes button in the INPUT section.

4. Click on the Assessment ABC button.

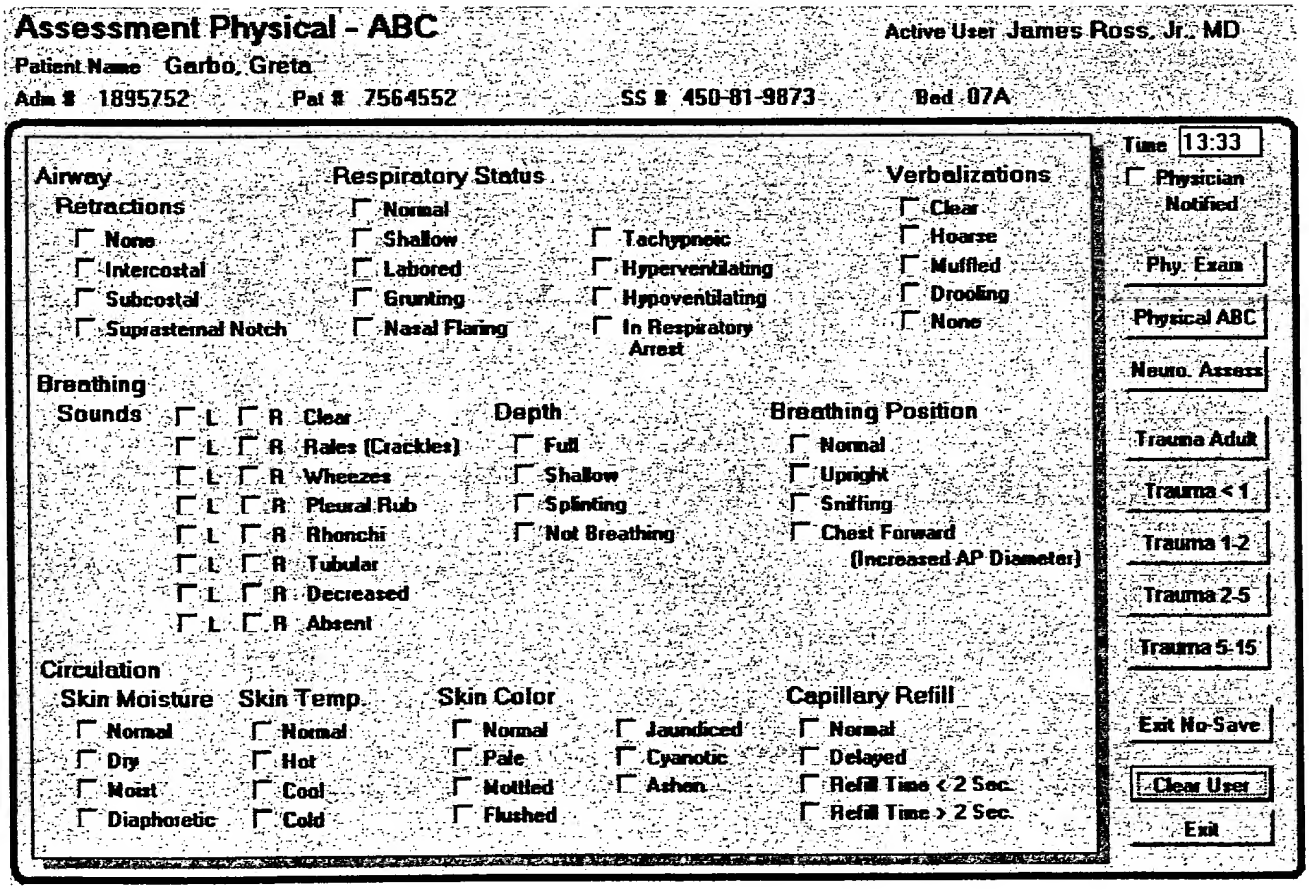
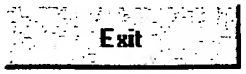


Figure Chapter 3: -152: Assessment Physical - ABC

(Image: assessment-physical-abc.bmp)

5. Enter (click on) all appropriate physical ABC conditions.



6. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Physical ABC

- You can review the Physical ABC record by clicking on the Summary or Progress Notes Summary buttons in the HISTORICAL section.
- ***Alternate access to this screen:***
  Nursing Physical Exam
  Assessment - Neuro
  All Truama screens

Entering Trauma Score (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Progress Notes

3. Click on the Progress Notes button in the INPUT section.

Assessment Trauma

4. Click on the Assessment Trauma button.

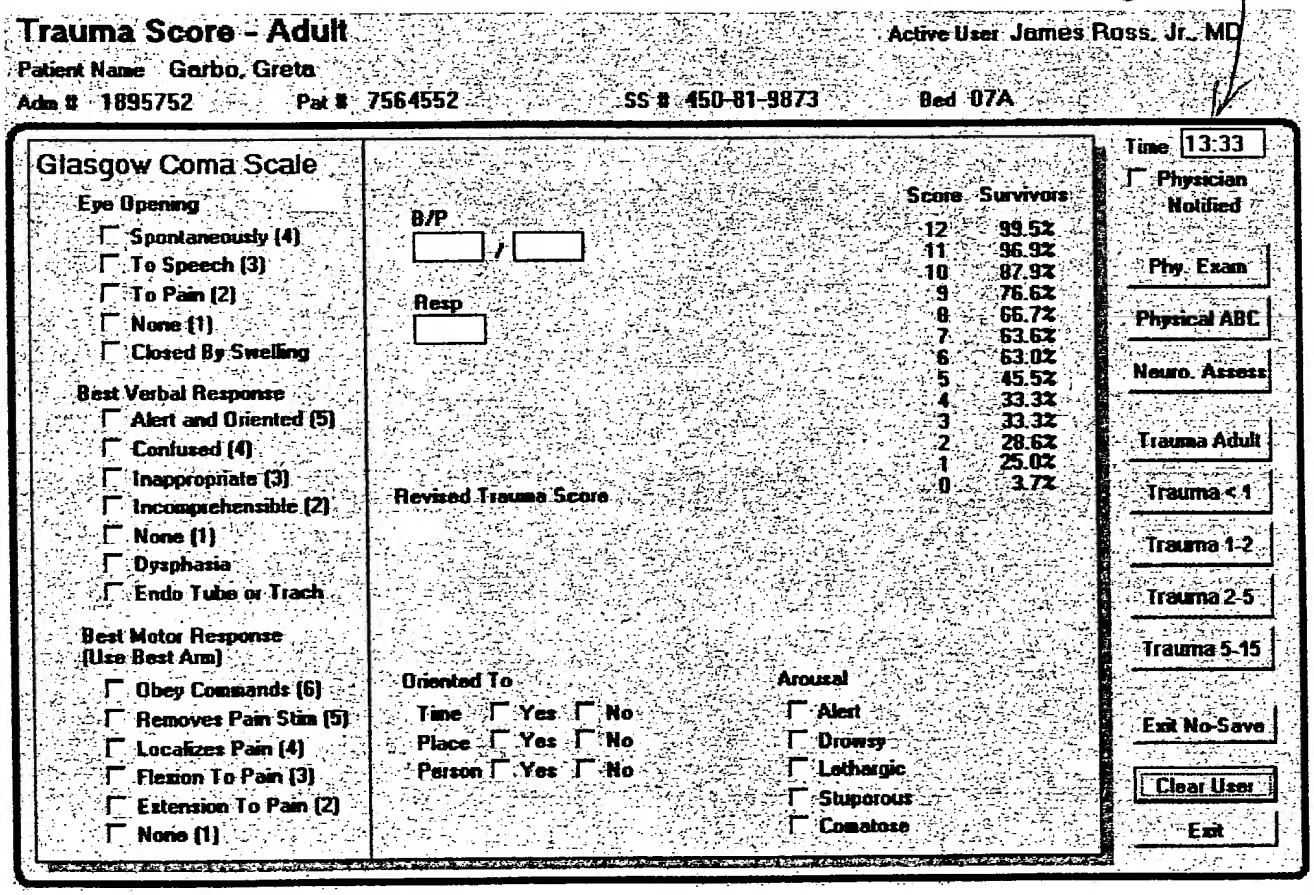


Figure Chapter 3: -153: Trauma Score (adult)

(Image: trauma-score-adult.bmp)

5. Enter (click on) all appropriate trauma conditions for the appropriate age groups (i.e. Trauma; *<1, 1-2, 2-5, 5-15*, and *Adult*).

Exit

6. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Trauma Score

- You can review the Trauma Score record by clicking on the Summary or Progress Notes Summary buttons in the HISTORICAL section.
- ***Alternate access to this screen:***

  Nursing Physical Exam
  Assessment - Neuro
  Assessment Physical -ABC
  All Truama screens

Medication Orders/Therapeutic Orders

Entering Medication Orders/Therapeutic Orders (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Progress Notes

3. Click on the Progress Notes button in the INPUT section.

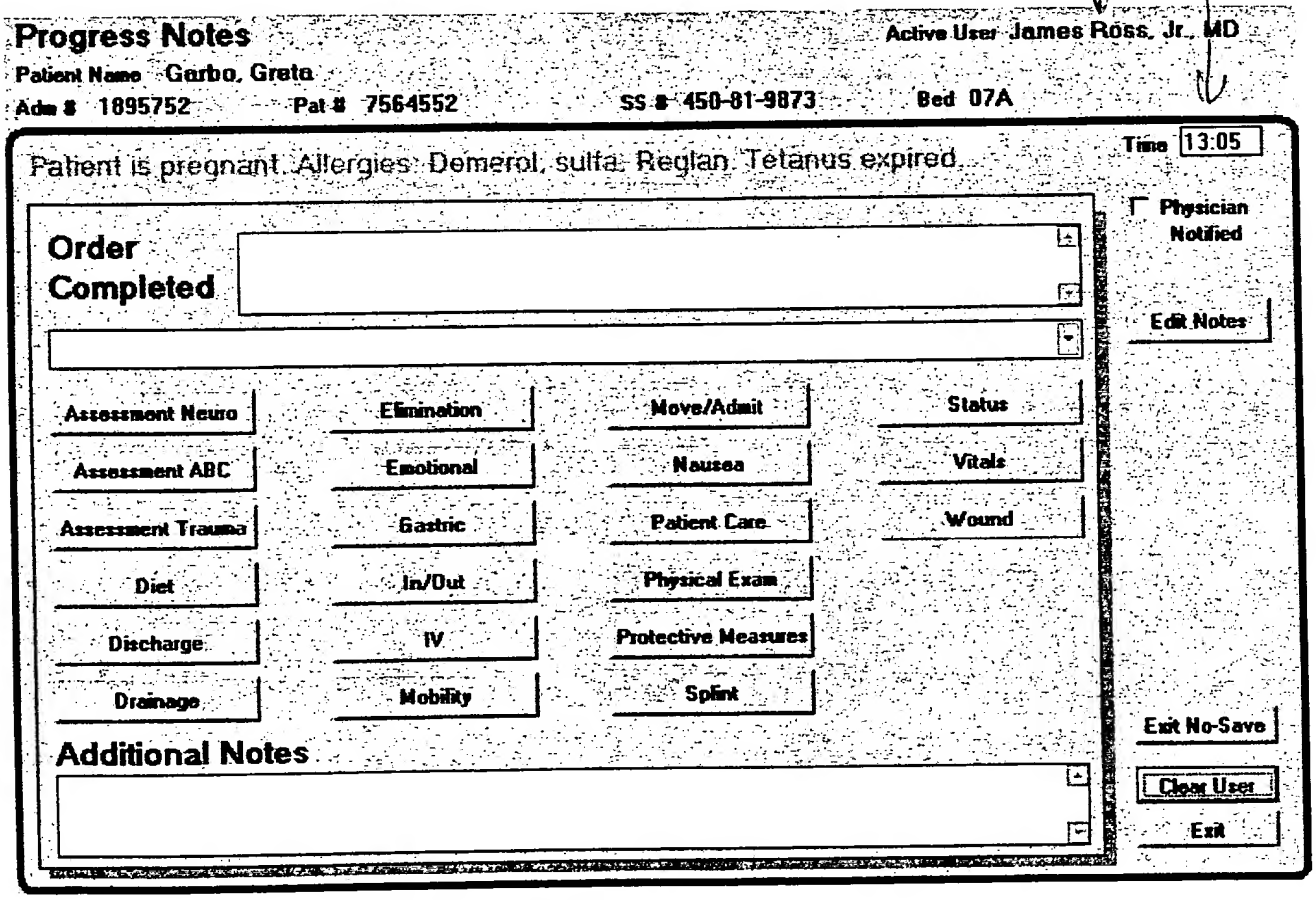


Figure Chapter 3: -154: Progress Notes

(Image: progress-notes.bmp)

5. Click on menu and form fields and complete as appropriate.

Exit

6. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Orders

- You can review the Progress Notes record by clicking on the Summary or Progress Notes Summary buttons in the HISTORICAL section.

Entering IV (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Progress Notes button in the INPUT section.

4. Click on the IV button.

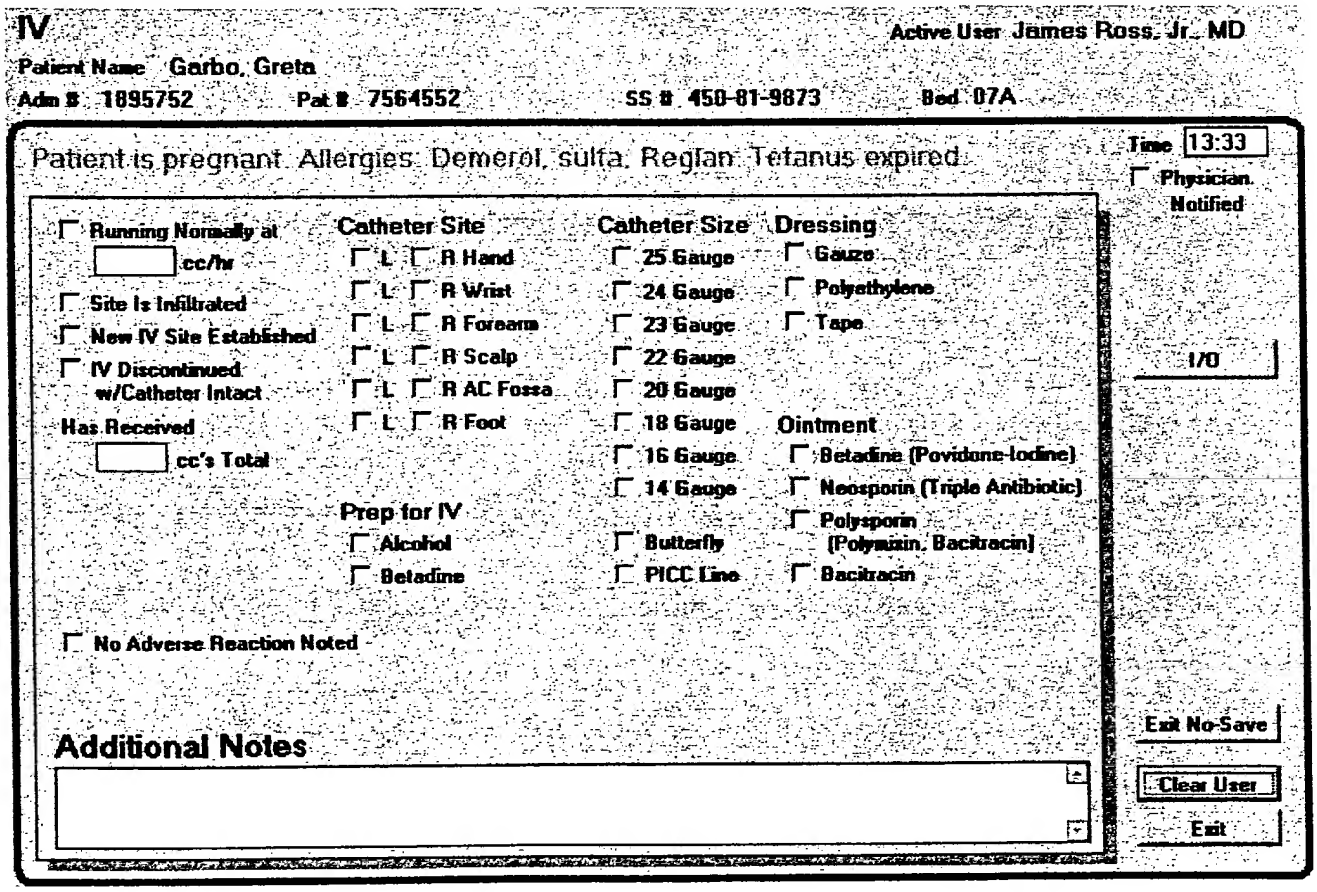


Figure Chapter 3: -155: IV

(Image: iv.bmp)

5. Click on check boxes and form fields to complete as appropriate.

6. Click the Exit button to return to the Medical Information screen.

Tips and Hints: IV

- You can review the IV record by clicking on the Summary or Progress Notes Summary buttons in the HISTORICAL section.
- ***Alternate access to this screen:***
  Intake/Output
  Gastric/Suction
  Elimination
  Drainage/Nausea/Vomiting

Wound/Splint Management

Entering Wound Management (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Vital Signs

3. Click on the Progress Notes button in the INPUT section.

Wound

4. Click on the Wound button.

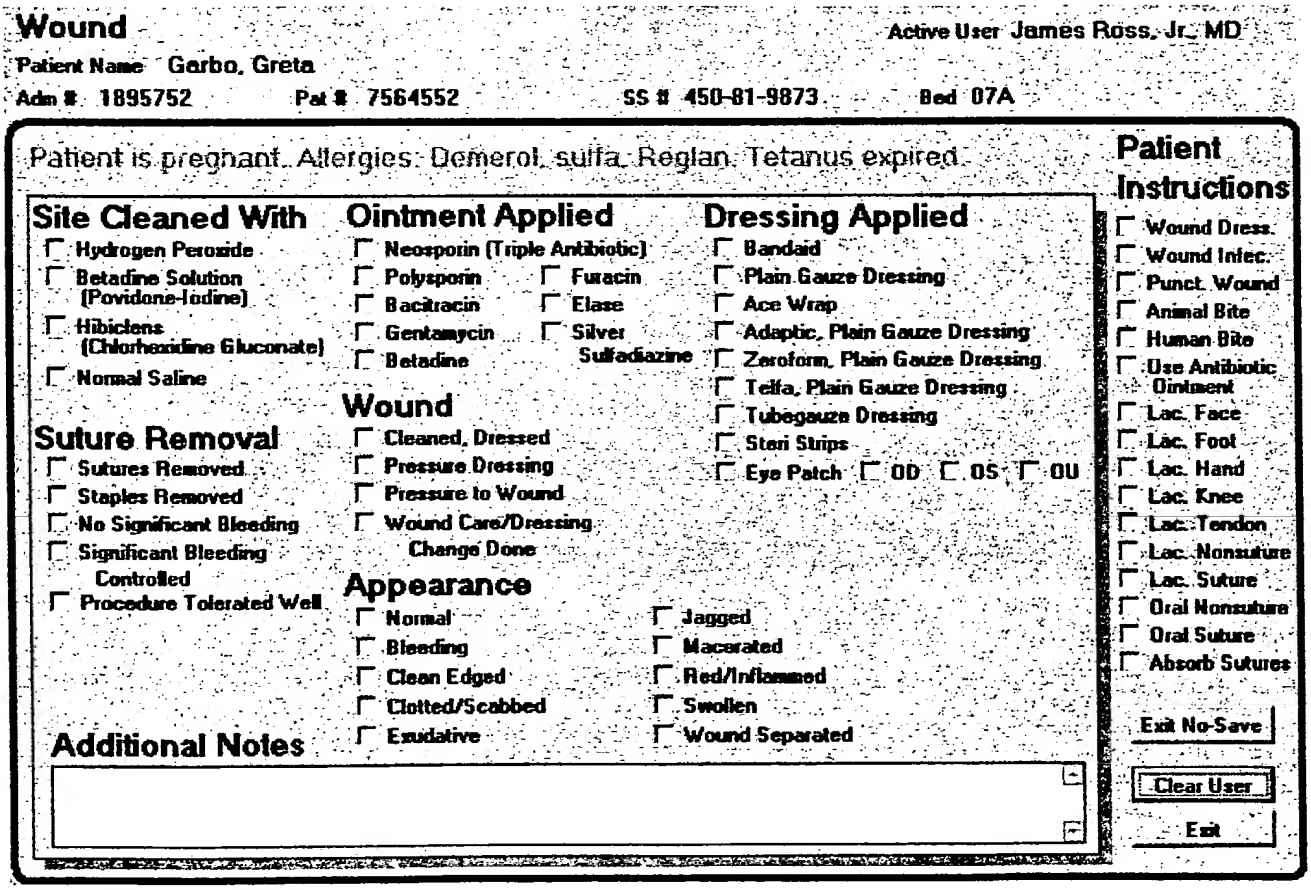


Figure Chapter 3: -156: Wound

(Image: wound.bmp)

5. Click on check boxes and form fields to complete as appropriate.

Exit

6. Click the Exit button to return to the Medical Information screen.

Entering Splint Management (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Progress Notes button in the INPUT section.

4. Click on the Splint button.

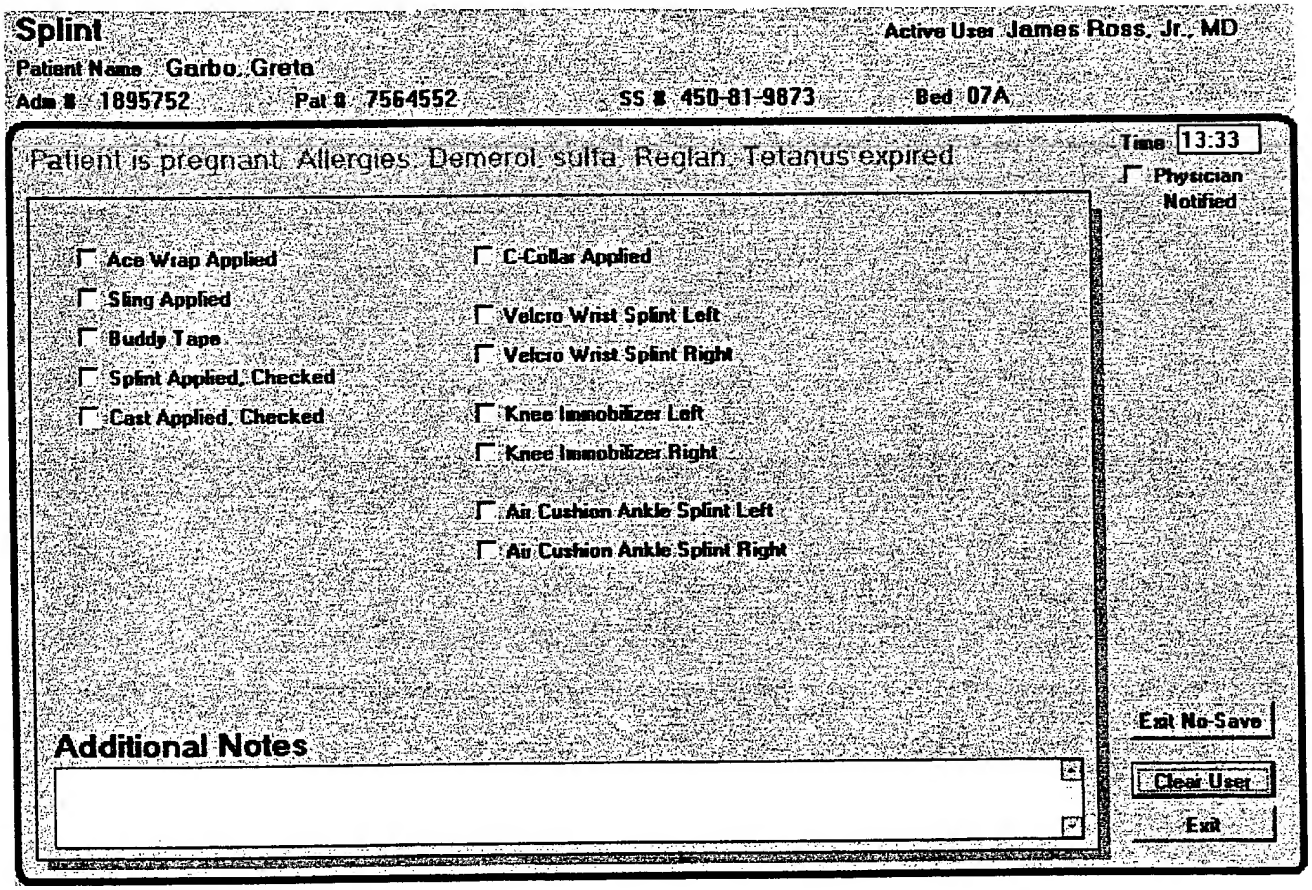


Figure Chapter 3: -157: Splint

(Image: splint.bmp)

5. Click on check boxes and form fields to complete as appropriate.

6. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Wound and Splint

- You can review the Wound and Splint record by clicking on the Summary or Progress Notes Summary buttons in the HISTORICAL section.

Patient Status Documentation

Patient Status Entry (std. menu) - Status

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Progress Notes button in the INPUT section.

4. Click on the Status button.

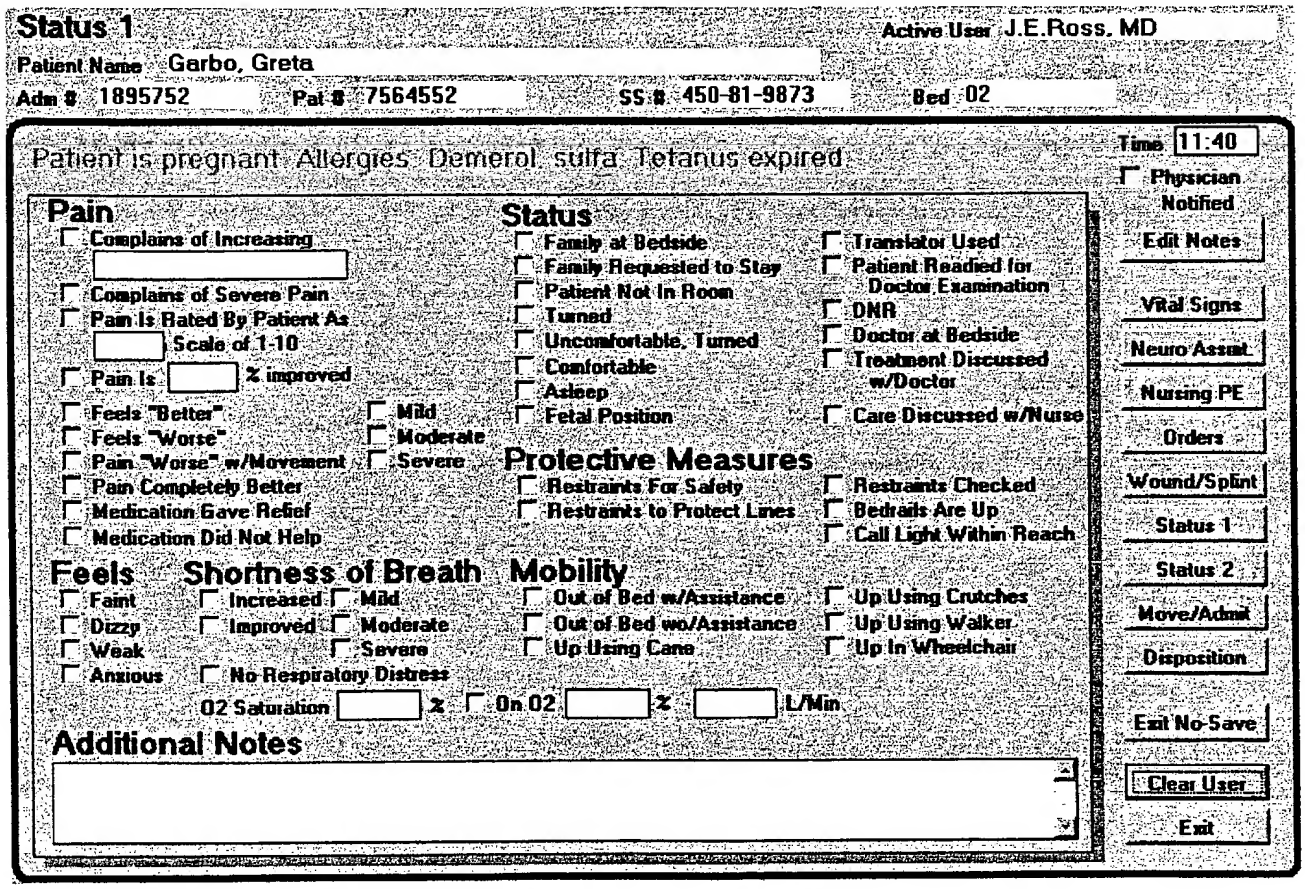


Figure Chapter 3: -158: Status

(Image: status.bmp)

5. Click on check boxes and form fields to complete as appropriate.

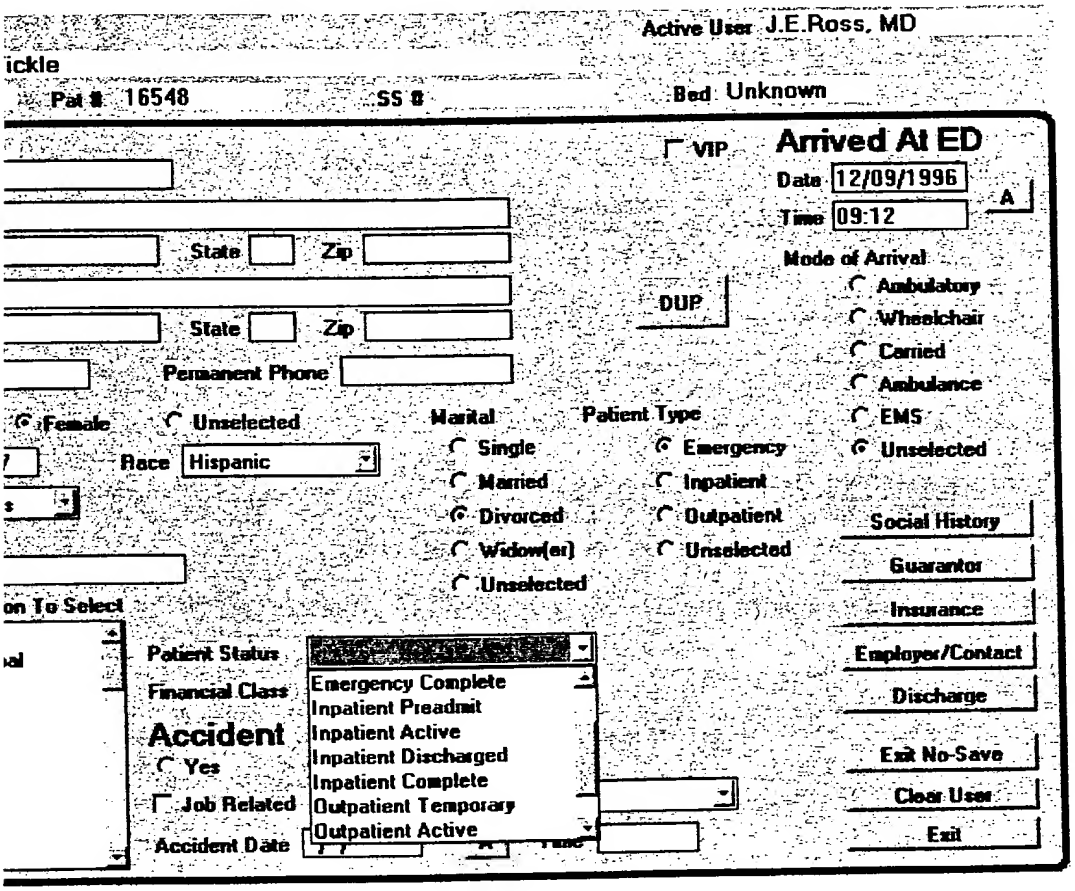
6. Click the Exit button to return to the Medical Information screen.

utput (I&O)

Imission

Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).
2. Click the Medical Information button.
3. Click on the Admission button at the right of screen.
4. Click on the "Patient Status" pull down menu.



3: -170: Admission (Patient Status)

5. Click on check boxes and form fields to complete as appropriate.
6. Click the Exit button to return to the Medical Information screen.

Entering Patient Output

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Discharge button at the right of screen.

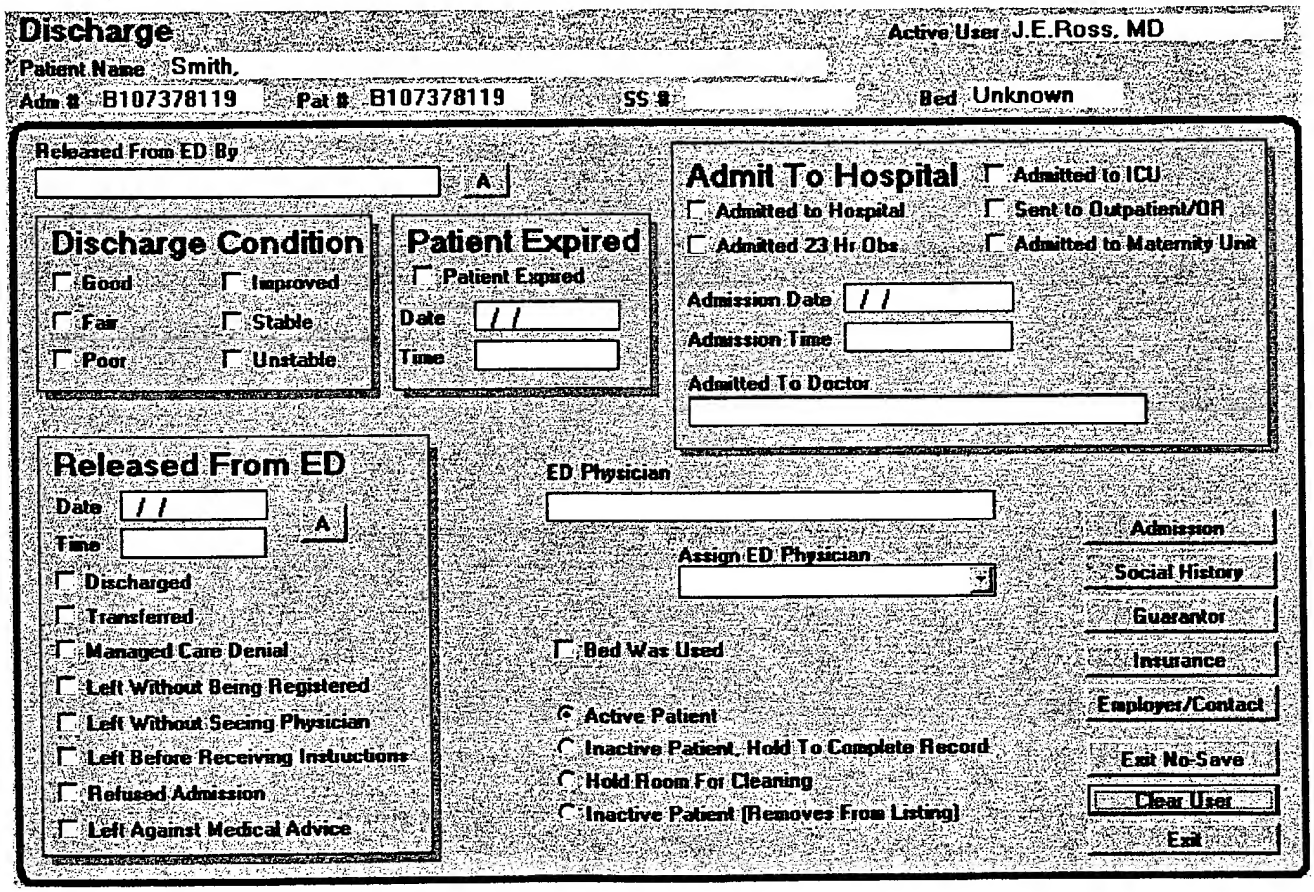


Figure Chapter 3: -171: Discharge

(Image: discharge.bmp)

5. Click on check boxes and form fields to complete as appropriate.

6. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Patient Input & Output (I&O)

- *Alternate access to these screens:*
  - Admission
  - Discharge
  - Employer/Contact
  - Guarantor
  - Insurance
  - Social History

Editing Progress Notes

Modify Progress Notes (std. menu)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Progress Notes button in the INPUT section.

4. Click on the Edit Notes button and enter password at prompt.

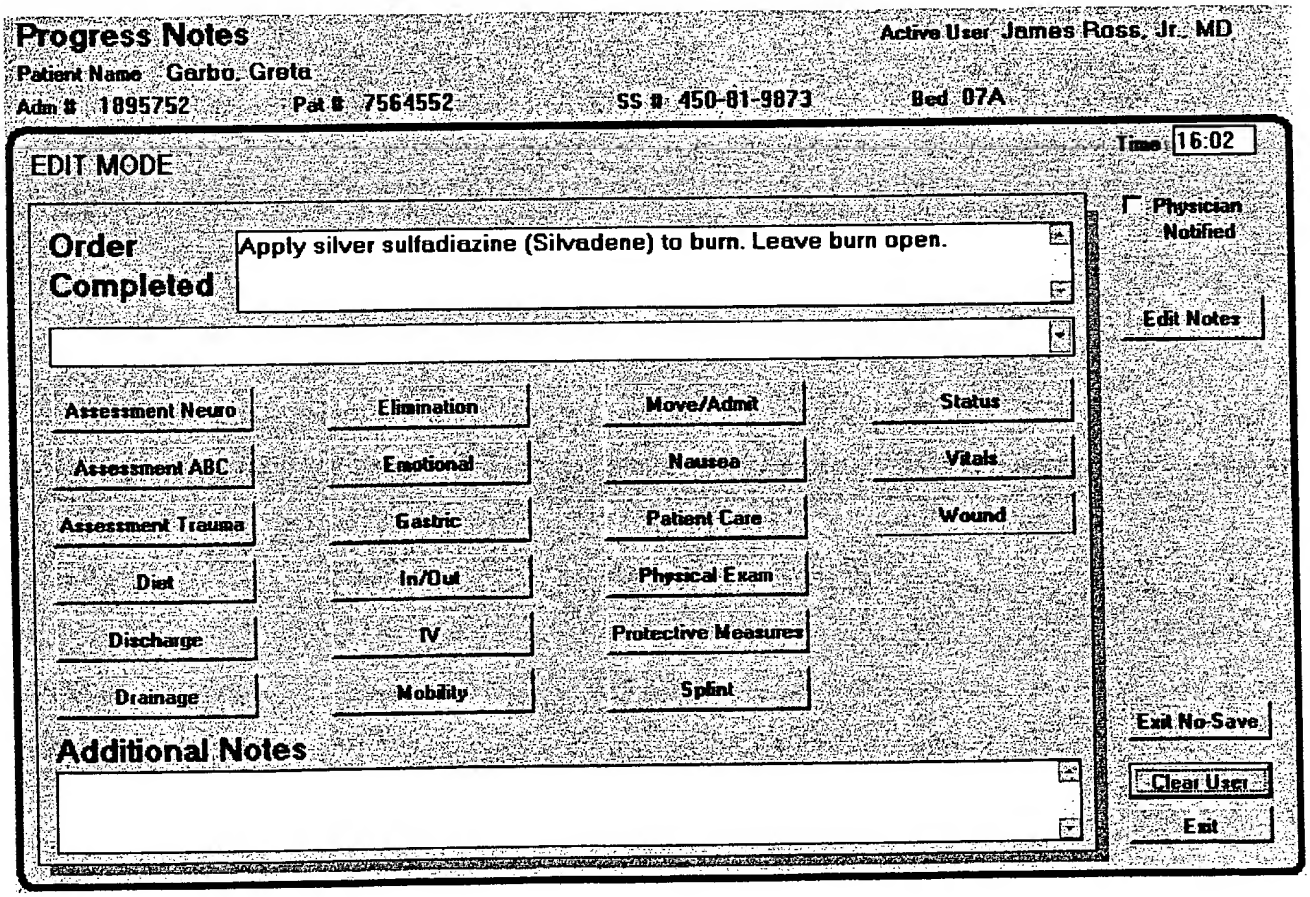


Figure Chapter 3: -172: Progress Notes - Edit

(Image: progress-notes-edit-mode.bmp)

5. Click on the multiline form field to manually add or modify any text.

6. Click the Exit button to return to the Medical Information screen.

Tips and Hints: Progress Notes

- You can review the Progress record by clicking on the Summary or Progress Notes Summary buttons in the HISTORICAL section.

Progress Notes Review

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

2. Click the Medical Information button.

3. Click on the Progress Notes Summary button in the HISTORICAL section.

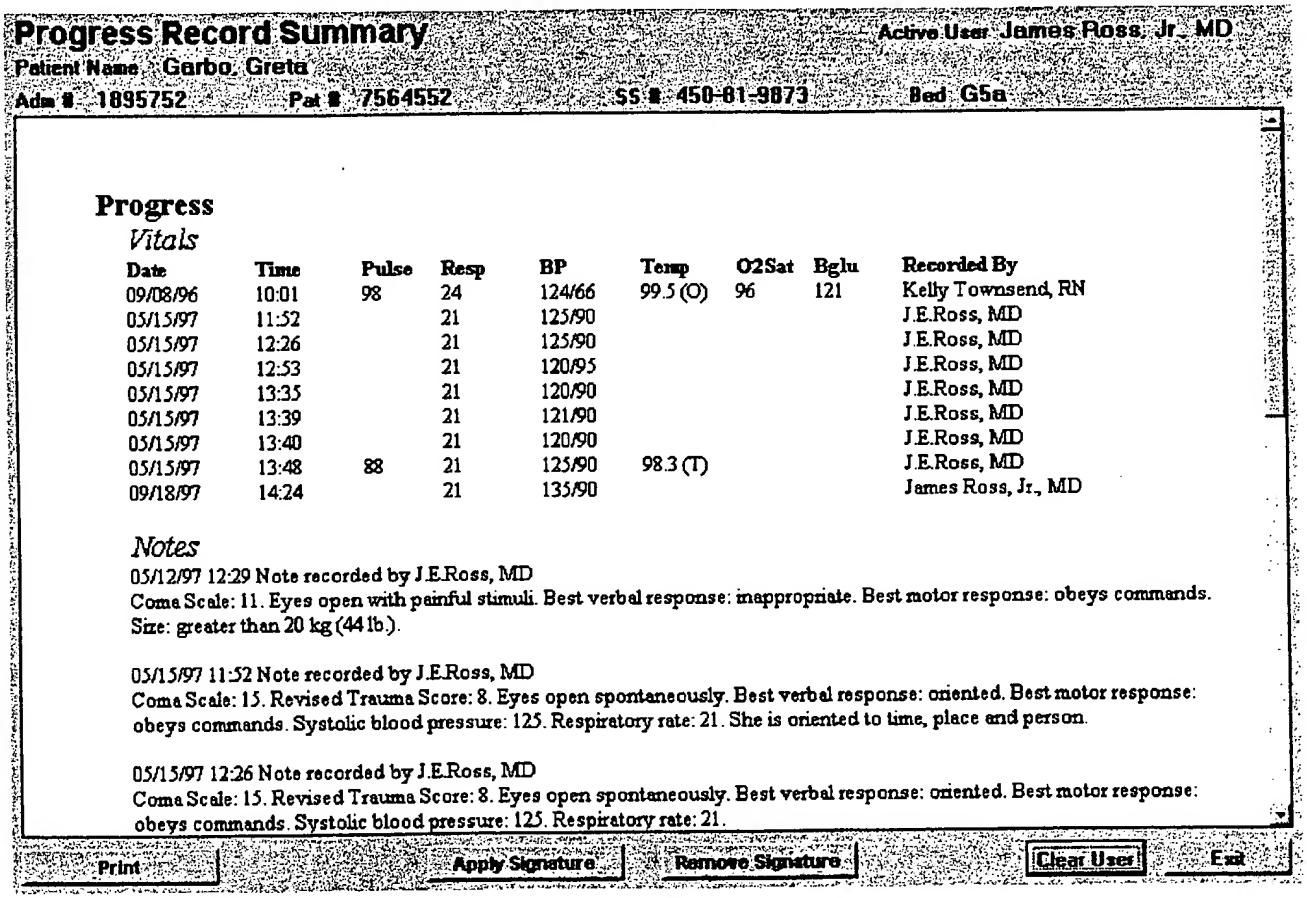


Figure Chapter 3: -173: Progress Record Summary

(Image: progress-record-summary.bmp)

4. Click the Exit button to return to the Medical Information screen.

Nurse Notes Electronic Signatures

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu).

Medical Information

2. Click the Medical Information button.

Prog. Notes Summary

3. Click on the Progress Notes Summary *or* Summary buttons in the HISTORICAL section.

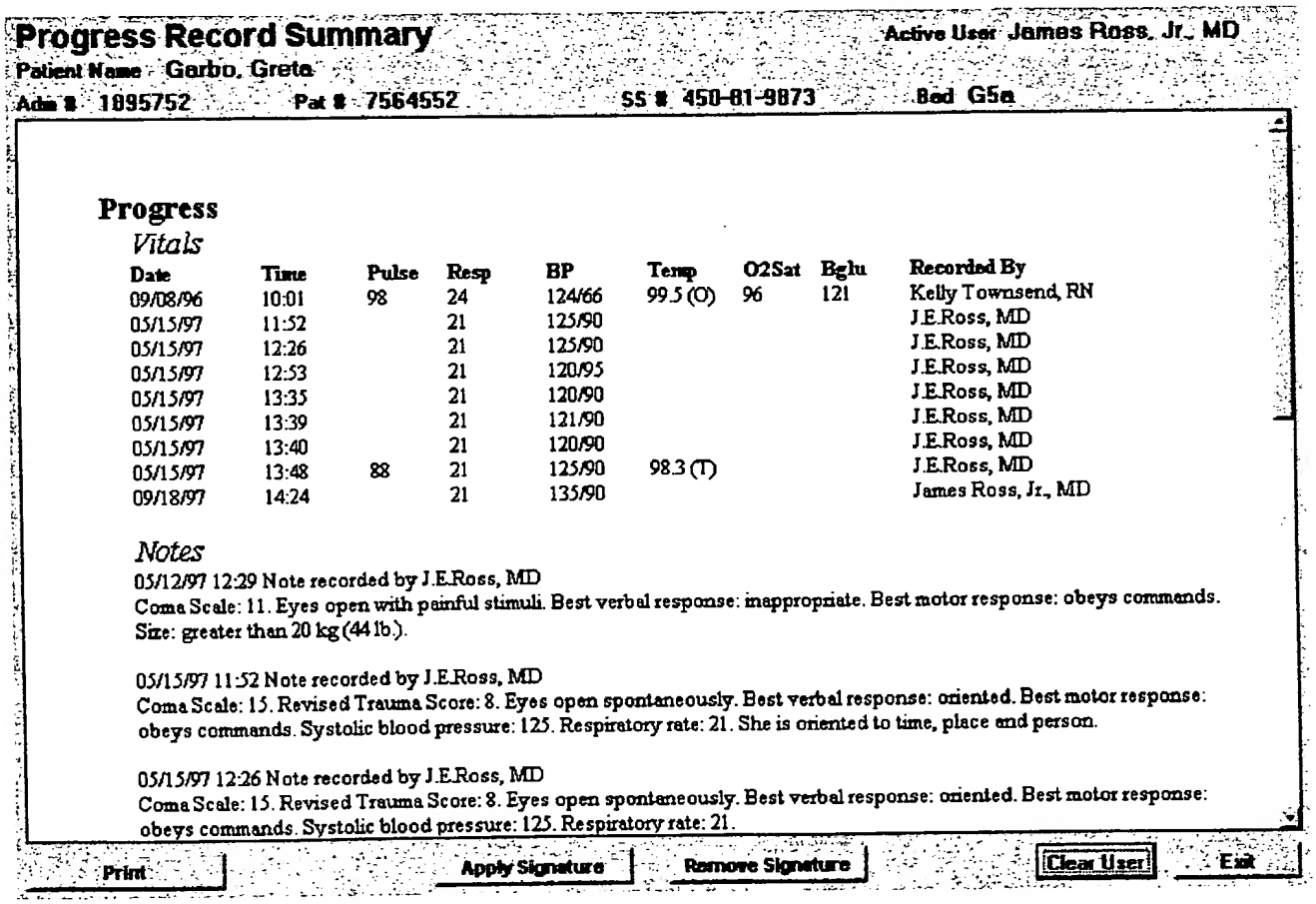


Figure Chapter 3: -174: Progress Record Summary

(Image: progress-record-summary.bmp)

Apply Signature
Remove Signature

4. Click on Apply or Remove Signature buttons as required.

Exit

5. Click the Exit button to return to the Medical Information screen.

TeleMed Department Clerks Section

Status Updates (X-Ray, Orders, Labs and Tests)

From the "Active Patient List" (your main tracking screen)

1. Select a patient from the "Grease Board" (list menu)

2. Click the Medical Information button.

3. Click on the Department Clerk button at the right of screen.

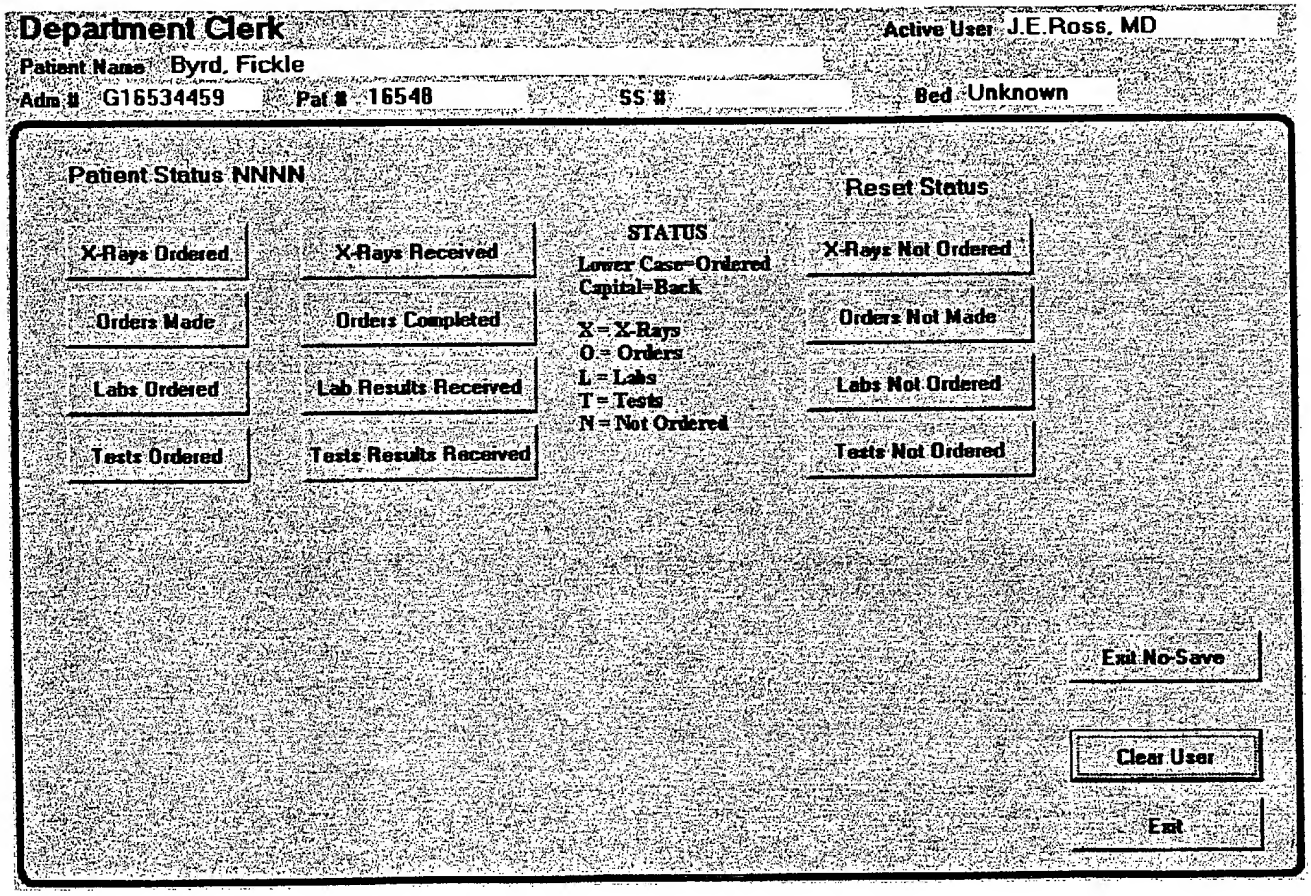


Figure Chapter 3: -175: Department Clerk

(Image: department-clerk.bmp)

4. Click the appropriate status button(s) for X-Ray, Orders, Labs and Tests as ordered received or reset as required.

5. Click the Exit button to return to the Medical Information screen.

TeleMed Emergency Department Logs and Reports

Logs and Reports

Accessing the Reports Generator

- *From the "Active Patient List" (your main tracking screen)*

1. Click the Utilities button.

2. Click on the Reports button at the left of screen.

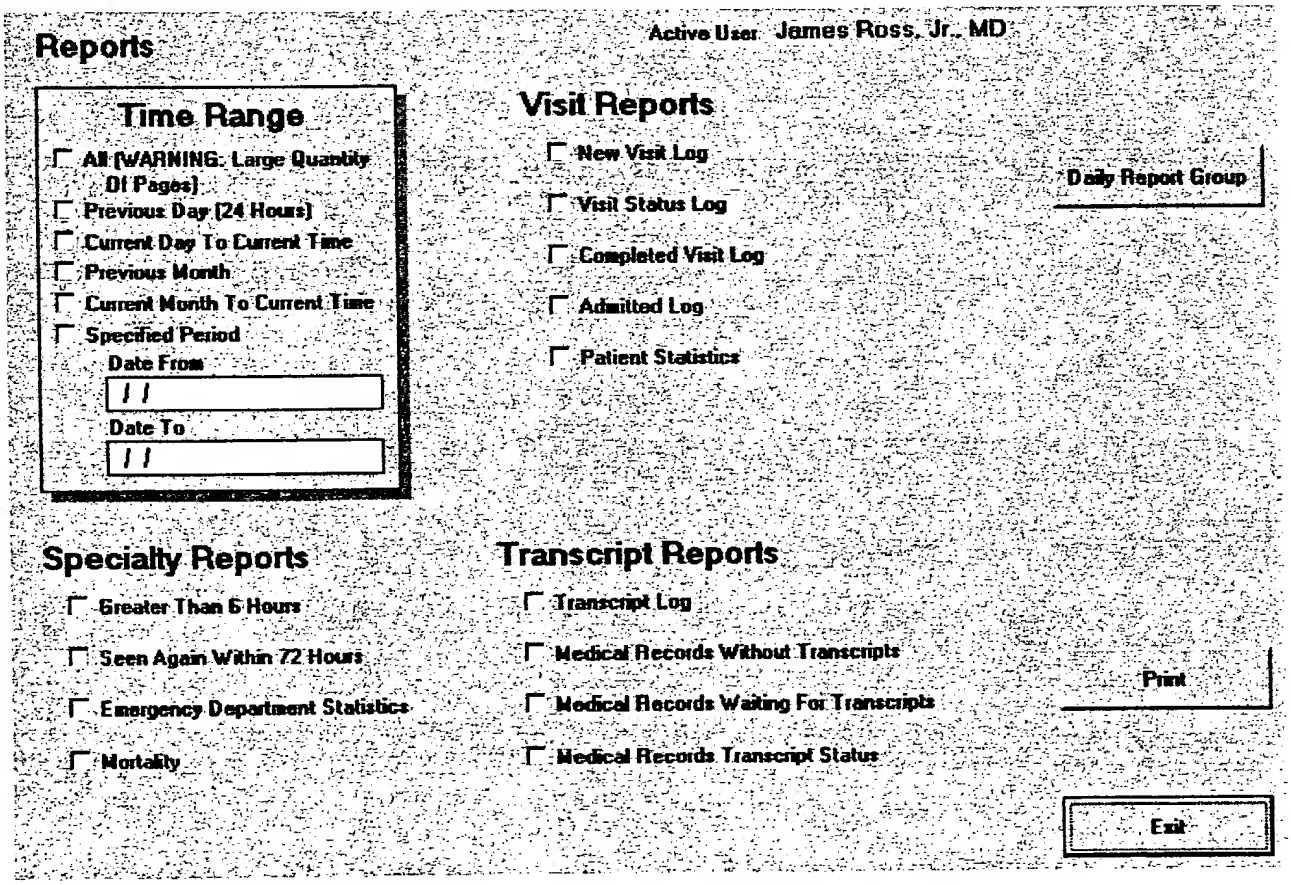


Figure Chapter 3: -176: Reports (Generator)

(Image: reports.bmp)

4. Select the Time Range settings for your report.

Printing Visit Reports

Continued from Accessing the Reports Generator, Page 264.

5. Select any combination of reports under "Visit Reports" at upper center of screen (New Visit Log, Visit Status Log and/or Completed Visit Log).

6. Click on the Print button at the right of screen.

Tips and Hints: Visit Reports

- **New Visit Log** provides a listing of the following visit information for selected period of time:
  - Patient #, Admission #, Arrival Date/Time, Patient Name, Sex, ED Physician
- **New Visit Log** provides the following summary information for selected period of time:
  - # Total Visits
  - # Visits Using Beds,
  - % Visits Using Beds

◊ **Visit Status Log** provides a listing of the following visit information for selected period of time:
  - Visit Date/Time, Admission #, Patient Name, Exit Status

◆ **Completed Visit Log** provides a listing of the following visit information for selected period of time:
  - Arrival Date/Time, Discharge Time, Admission #, Patient Name, Sex, Birth Date / Age, Arrive By

◆ **Completed Visit Log** provides the following summary information for selected period of time:
  - # Expired
  - # Released
  - # Transferred
  - # Left - Managed Care Denial
  - # Left W/O Being Registered
  - # Left W/O Seeing Physician
  - # Left Before Receiving Instructions
  - # Refused Admission
  - # Left Against Medical Advice
  - # Admitted To Hospital
  - # Admitted 23 Hr Observation
  - # Admitted ICU
  - # Sent To Outpatient
  - # Admitted To Maternity
  - # Total Patients

Specialty Reports

Printing Specialty Reports

Continued from Accessing the Reports Generator, Page 264.

5. Select any combination of reports under "Specialty Reports" at lower left of screen (Greater Than 6 Hours, Seen Again Within 72 Hours, Emergency Department Statistics, Mortality).

6. Click on the Print button at the right of screen.

Tips and Hints: Specialty Reports

- **Greater Than 6 Hours & Seen Again Within 72 Hours** provides a listing of the following visit information for selected period of time:
  - Arrival Date/Time, Discharge Time, Admission #, Patient Name, Sex, Birth Date / Age, Arrive By
- **Greater Than 6 Hours & Seen Again Within 72 Hours** provides the following summary information for selected period of time:
  - # Expired
  - # Released
  - # Transferred
  - # Left - Managed Care Denial
  - # Left W/O Being Registered
  - # Left W/O Seeing Physician
  - # Left Before Receiving Instructions
  - # Refused Admission
  - # Left Against Medical Advice
  - # Admitted To Hospital
  - # Admitted 23 Hr Observation
  - # Admitted ICU
  - # Sent To Outpatient
  - # Admitted To Maternity
  - # Total Patients

◊ **Emergency Department Statistics** provides a listing of visit information totals for selected period of time:
  - Date
  - Discharged
  - Admitted ICU
  - Regular Admission
  - 23 Hr Observation
  - Sent To Outpatient/OR
  - Managed Care Denial
  - Left Without Being Seen
  - Left Before Receiving Instructions
  - Refused Admission
  - Left Against Medical Advice
  - Transferred
  - Expired
  - Total registered
  - Left Without Being Registered
  - Admitted To Maternity

♦ **Mortality Log** provides a listing of the following visit information for selected period of time:
  - Arrival Date/Time, Discharge Time, Admission #, Patient Name, Sex, Birth Date / Age, Arrive By

♦ **Mortality Log** provides the following summary information for selected period of time:
  - # Expired
  - # Released
  - #Transferred
  - # Left - Managed Care Denial
  - # Left W/O Being Registered
  - # Left W/O Seeing Physician
  - # Left Before Receiving Instructions
  - # Refused Admission
  - # Left Against Medical Advice
  - # Admitted To Hospital
  - # Admitted 23 Hr Observation
  - # Admitted ICU
  - # Sent To Outpatient
  - # Admitted To Maternity
  - # Total Patients

Transcript Reports

Printing Transcript Reports

Continued from Accessing the Reports Generator, Page 264.

5. Select any combination of reports under "Transcript Reports" at lower center of screen (Transcript Log, Medical Records Without Transcript Logs, Medical Records Waiting For Transcripts, Medical Records Transcript Status).

6. Click on the Print button at the right of screen.

Tips and Hints: Transcript Reports

- (Received and Processed) **Transcript Log** provides a listing of the following visit information for selected period of time:
  - Arrival Date/Time, Dictation Date/Time, Received Date/Time, ED Physician, Admission #, Patient Record Name, #, Patient Dictated Name
- (Received and Processed) **Transcript Log** provides the following summary information for selected period of time:
  - # Total Transcripts

◊ **Medical Records Without Transcript & Medical Records Waiting For Transcripts** provides a listing of totals for the following visit information for selected period of time:
  - Arrival Date/Time, Admission #, Patient #, Patient Name, ED Physician

◊ **Medical Records Without Transcript & Medical Records Waiting For Transcripts** provides the following summary information for selected period of time:
  - # Total Visits
  - # Selected Visits

♦ **Medical Records Transcript Status** provides a listing of the following visit information for selected period of time:
  - Arrival Date/Time, Admission #, Patient #, Patient Name, ED Physician

♦ **Medical Records Transcript Status** provides the following summary information for selected period of time:
  - # Total Visits

Daily Report Group

Printing Daily Report Group

Continued from Accessing the Reports Generator, Page 264.

5. Click on the Daily Report Group button at the right of screen.

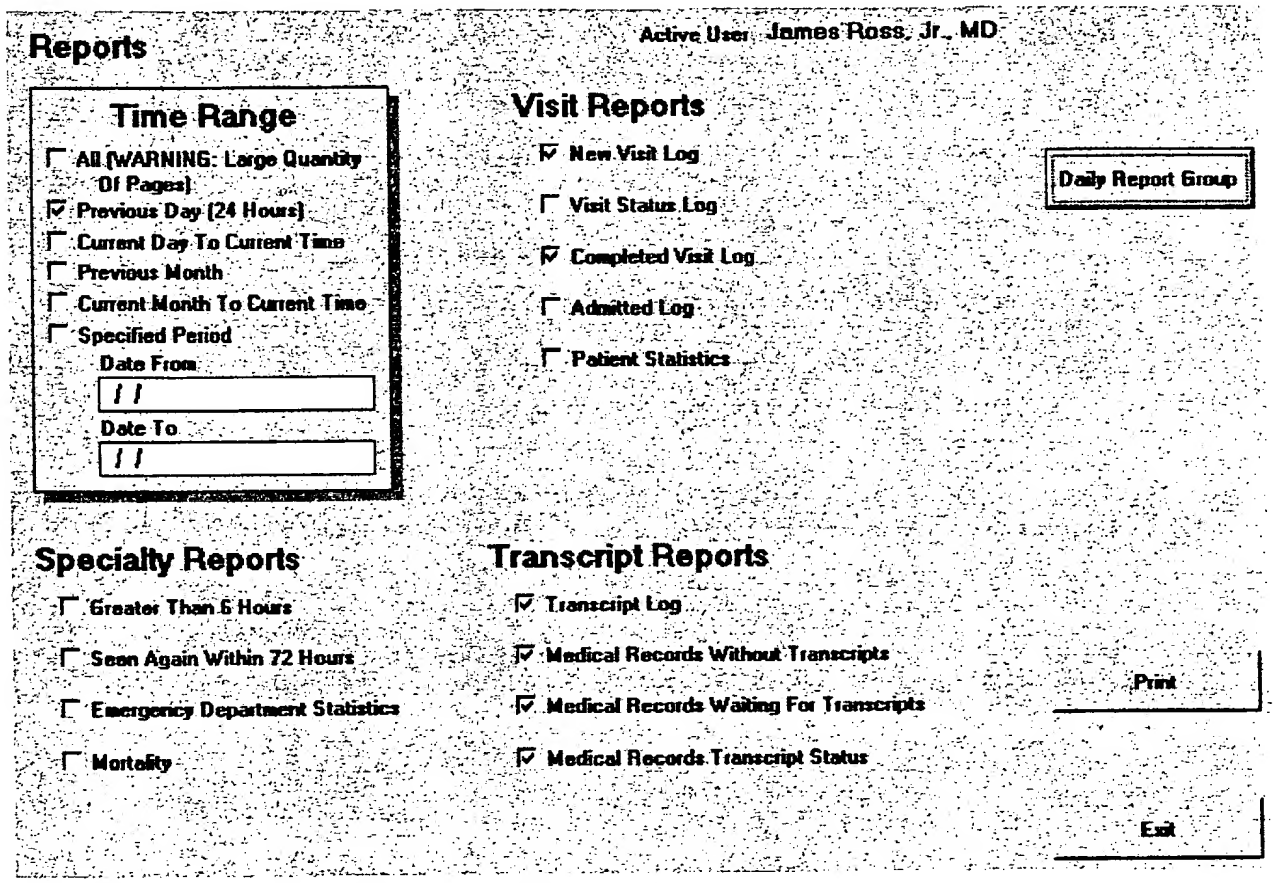


Figure Chapter 3: -177: Reports (Generator), Daily Report Group Selected

(Image: reports-drg.bmp)

6. Click on the Print button at the right of screen.

Tips and Hints: Daily Report Group

The Daily Report Group option provides the following combination of logs:

- **New Visit Log** provides a listing of the following visit information for the previous 24 hours:
  - Patient #, Admission #, Arrival Date/Time, Patient Name, Sex, ED Physician
- **New Visit Log** provides the following summary information for the previous 24 hours:
  - # Total Visits
  - # Visits Using Beds,
  - % Visits Using Beds

◊ **Completed Visit Log** provides a listing of the following visit information for selected period of time:
  - Arrival Date/Time, Discharge Time, Admission #, Patient Name, Sex, Birth Date / Age, Arrive By

◊ **Completed Visit Log** provides the following summary information for the previous 24 hours:
  - #
  - Expired
  - # Released
  - # Transferred
  - # Left - Managed Care Denial
  - # Left W/O Being Registered
  - # Left W/O Seeing Physician
  - # Left Before Receiving Instructions
  - # Refused Admission
  - # Left Against Medical Advice
  - # Admitted To Hospital
  - # Admitted 23 Hr Observation
  - # Admitted ICU
  - # Sent To Outpatient
  - # Admitted To Maternity
  - # Total Patients

♦ (Received and Processed) **Transcript Log** provides a listing of the following visit information for the previous 24 hours:
  - Arrival Date/Time, Dictation Date/Time, Received Date/Time, ED Physician, Admission #, Patient Record Name, #, Patient Dictated Name

♦ (Received and Processed) **Transcript Log** provides the following summary information for the previous 24 hours:
  - # Total Transcripts

* **Medical Records Without Transcript & Medical Records Waiting For Transcripts** provides a listing of totals for the following visit information for the previous 24 hours:
  - Arrival Date/Time, Admission #, Patient #, Patient Name, ED Physician

* **Medical Records Without Transcript & Medical Records Waiting For Transcripts** provides the following summary information for the previous 24 hours:
  - # Total Visits
  - # Selected Visits

⇒ **Medical Records Transcript Status** provides a listing of the following visit information for the previous 24 hours:
  - Arrival Date/Time, Admission #, Patient #, Patient Name, ED Physician

⇒ **Medical Records Transcript Status** provides the following summary information for the previous 24 hours:
  - # Total Visits

Doctor/Patient List

Printing Doctor/Patient List

From the "Active Patient List" (your main tracking screen)

1. Click the Utilities button.

2. Click on the Doc/Patient List button at the left of screen.

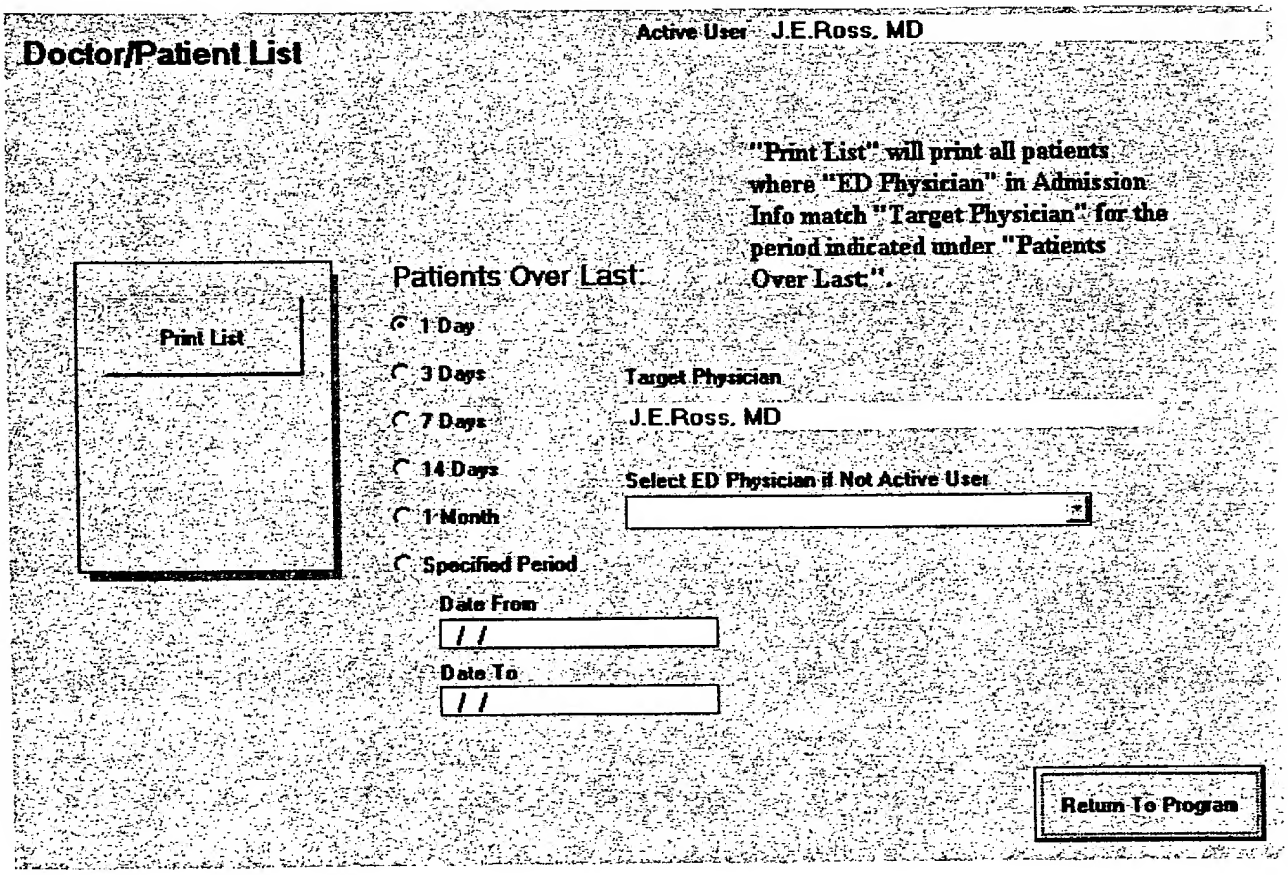
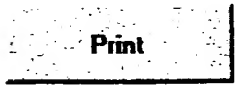


Figure Chapter 3: -178: Doctor/Patient List

(Image: doc-patient-list.bmp)

4. Select the Time Range settings for your report (center of screen).
5. Enter ED Physician (refer to pull down menu if other than you).



6. Click on the Print button.

Tips and Hints: Doctor/Patient List

- Doctor/Patient List provides the following visit information for the selected period of time:
  - Visit Date/Time, Admission #, Patient Name, Exit Status

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Chapter 4: Support Services

TeleMed™ Service

Under the TeleMed Service program, RLIS provides support services to your local help desk and users. It's the practical, economical solution for hospitals with distributed information service groups and TeleMed software users. Three levels of support are offered under this program:

- **Platinum Key Support:** Includes toll-free telephone support*, toll-free access to TeleMed's Electronic Services, Remote Services, master copies of all maintenance releases, Quarterly Updates† and periodic upgrades† to the current version of your licensed software and On-Site‡ Technical Support. Mission Critical Support includes Level 1, 2, 3 & 4 support†. All clients and servers must be running the current version of TeleMed software when entering the Mission Critical Support program.
- **Gold Key Support:** Includes toll-free telephone support*, toll-free access to TeleMed's electronic services, Quarterly Updates† and periodic upgrades† to the current version of your licensed software and "per visit" on-site technical services. Standard Support includes Level 1*, 2 & 3 support†.
- **Silver Key Support:** Provides all Quarterly Updates† and periodic upgrades† to the current version of your licensed software and "per call and per visit" technical services. All users must own the current version of TeleMed software when entering the Basic Support program.

♦ **Remote Link Discount Option:** When selecting the Remote Link Option, all sites that provide TeleMed dedicated ISDN connection(s) to their TeleMed servers will receive a discount on any of the three support options.

* Level 1 - 24 hr. x 7 day for Mission Critical Support, 8 AM -5 PM CT Mon.-Fri. for Standard Support,
Level 2 & 3 - 8 AM to 5 PM Central Time

† see "Definitions" section of your support contract for descriptions

‡ as determined by TeleMed Service staff

Your hospital's administration group in charge of service contracts will know the terms of your service contract.

Contacting TeleMed Help Desk

You can reach TeleMed support via phone or fax.
Phone: ~~800-495-1547~~ *or* (210) 490-1800
Fax: 210-495-8899

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Appendix A: TeleMed License Agreement

RLIS and Licensee agree that the following terms and conditions will apply to all computer program products, user manuals, other documentation and services ("Program(s)") provided by RLIS to Licensee including Program(s) specified in any "Schedule" executed by both parties. The term Program(s) also includes any subsequent updates, modifications and enhancements to the Program(s) that are furnished by RLIS to Licensee.

1. License. RLIS hereby grants to Licensee a nonexclusive license (the "License") to use the Program(s) internally in the United States in accordance with the terms and conditions set forth in this Agreement and the relevant "Schedule." The License authorizes the use of the Program documentation furnished by RLIS and the use of any subsequent updates to the Program(s) that are furnished by RLIS to Licensee. The License authorizes the Licensee to Install or use the copy of the Program(s) furnished to Licensee, and the back-up or archival copy made by Licensee, only on a single central processing unit ("CPU") (or authorized server(s) and workstation(s) under the network option license) identified by machine identification numbers provided by Licensee to RLIS. Installation or use of the Program(s) on more than one CPU at the same time requires a separate License for each such installation or use. Licensee may physically transfer the Program(s) from one CPU to another, provided that the Program(s) reside on only one CPU at a time. Licensee may not install the Program(s) on a network or electronically transfer the Program(s) from one CPU to another via a network, unless Licensee has obtained a network option for the Program from RLIS.

If RLIS delivers a network option for the Program(s) to Licensee, each such option shall consist of a network option license which shall authorize the Licensee to install and operate the Program(s) or the licensed server or workstation part of the Program(s), as the case may be, on a single authorized server or multiple workstations or clients identified by a machine identification number and located at a site provided by Licensee to RLIS so that the Program(s) may be accessed by users only in a network designated by Licensee only by means of the authorized server(s).

Unless otherwise specified in the relevant "Schedule", the maximum number of concurrent users for Program(s) licensed in a network option shall be limited to the maximum number of licenses granted to Licensee and in effect for such Program(s) or, in the case of updates to the Program(s) delivered under Support Services, the maximum number of licenses for which Licensee has purchased Support Services. Use of Programs in a network option by additional concurrent users shall require that Licensee purchase a commensurate number of additional licenses or, in the case of updates, Support Services for a commensurate number of licenses.

Licensee shall promptly notify RLIS of any changes in the machine identification number or location of the authorized servers(s) or workstation(s) or CPU(s) from the one originally specified. If Licensee wishes to substitute a different authorized server or workstation or CPU under this Agreement, Licensee shall notify RLIS and RLIS shall either provide the Program(s) on the different authorized server or workstation or CPU or enable the existing Program(s) to operate on the different authorized server or workstation or CPU as soon as reasonably practicable and Licensee shall pay RLIS the amount, if any, specified in the relevant "Schedule" attached hereto.

The Licenses cannot be assigned, sublicensed or otherwise transferred to another person or legal entity without the prior written consent of RLIS, except that Licensee may permit its majority owned subsidiary to exercise any of Licensee's rights under this Agreement, provided that (i) such subsidiary agrees (in a writing provided to RLIS if so requested) and Licensee hereby represents that subsidiary will comply with all the terms and conditions of this Agreement, and it does so comply, (ii) Licensee shall be liable for any violations of the terms and conditions contained herein, and (iii) no such subsidiary is in either direct or indirect competition with RLIS as a provider of computer-aided software engineering products or products to develop, implement and maintain business critical information systems.

The Program(s) may contain an automatic shut-off or time out feature which will disable the Program(s) after a predetermined period of time if Licensee fails to provide RLIS with CPU, server or workstation or other machine identification numbers.

2. Term. This Agreement shall commence as of the date upon which this Agreement is signed by both parties and this Agreement and the License(s) shall continue unless and until terminated pursuant to the provisions set forth in this Agreement.

3. Charges. All fees are payable in US dollars. Upon receipt of the Program(s), the license and/or service fee payment terms set forth in the "Schedule" shall be due and payable. Payment shall be made at the office of RLIS, Inc. at 4319 Medical Drive #131-341, San Antonio, Texas 78229, or as otherwise directed by RILS, Inc. in writing. Should Licensee request that delivery of the Program(s) occur more than thirty (30) days after execution of the "Schedule", such fees shall be subject to any changes in RLIS' commercial list prices. Licensee shall pay all sales, use, excise, and similar taxes applicable to the Program(s) and this Agreement and shall reimburse RLIS for any such taxes paid by RLIS, excluding taxes based on the net income of RLIS.

4. Delivery. RLIS shall deliver the computer programs to Licensee in the form of CD-ROM(s), diskette(s), or tape(s) containing machine readable code F.O.B. San Antonio, Texas, USA. In addition, RLIS shall provide Licensee with one set of RLIS' current user manual(s) for each computer program licensed hereunder describing the operation and use of that computer program.

5. Installation. RLIS shall install the computer programs as set forth in the Performance Criteria Checklist attached to this Agreement and executed by the parties.

6. Protection of Program. Licensee acknowledges that RLIS retains all title, copyrights, patents and other proprietary rights in and to the Program(s), including any and all copies, updates, modifications, enhancements, translations and other derivative works that duplicate or are based thereon. If RLIS provides consulting services, including on-site services or training services (collectively, the "Consulting Services") in connection with Licensee's use of the Program(s), such Consulting Services shall be provided at RLIS' then current rates. Licensee agrees any updates, modifications, enhancements, and translations to the Program(s) shall be the sole and exclusive property of RLIS, subject to use by the Licensee under

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7. Warranties, Disclaimer and Limitation. RLIS warrants that it has the right to grant the License(s) and that the Program(s) furnished to Licensee does not infringe any United States patent, copyright or trade secret rights of any third party. RLIS shall, at RLIS' expense, defend or settle any action brought against Licensee based on a claim that the Program(s) infringe a United States patent, copyright or trade secret right and will pay all costs and damages finally awarded against Licensee in any such action which are attributable to such claim; provided that (i) Licensee promptly notifies RLIS in writing of the claim; (ii) RLIS shall have sole control of the settlement and defense of any action to which this indemnity relates; and (iii) Licensee cooperates with RLIS in every reasonable way to facilitate such defense or settlement. If a Program becomes or, in opinion of RLIS, is likely to become the subject of a claim of infringement, RLIS may, at its option, procure for Licensee the right to continue using the Program, replace or modify it to make it non-infringing or, if it determines that neither of the foregoing alternatives is reasonably available to RLIS, then RLIS may terminate the License(s) for the Program upon forty-five (45) days notice to Licensee and refund the pro-rated (based on a 3 year depreciation "Schedule") license fee paid for the Program, and, except as set forth in this paragraph, RLIS shall leave no further liability to Licensee. RLIS shall not be liable for any infringement or claim thereof based upon the use of the Program(s) or any element of the Program(s) in combination with computer programs or hardware not supplied by RLIS, or upon any modification to the Program(s) made by any party other than RLIS.

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Licensee is solely responsible for: the selection of the Program(s) and the appropriate computer equipment for Licensee's needs. The proper use of the Program(s) by qualified personnel, taking measures to prevent loss of data and all other matters under its control. Except with regard to the warranty provided in the first paragraph of this section 6, RLIS' liability and contract, tort or otherwise with respect to any Program(s) and/or Support Services, shall not exceed the amount of the license fee(s) and support fee(s) paid to RLIS by Licensee with respect to such Program(s) during the preceding twelve (12) months.

IN NO EVENT SHALL RLIS BE LIABLE FOR SPECIAL, INCIDENTAL OR CONSEQUENTIAL DAMAGES, INCLUDING ANY DAMAGES RESULTING FROM LOSS OF USE, LOSS OF DATA, LOSS OF PROFITS OR LOSS OF BUSINESS, EVEN IF RLIS HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES.

8. Support Services. RLIS will provide the Support Services (as hereinafter defined) for the Program(s) free of charge during the Warranty Period, if any, set forth in the "Schedule" applicable to such Program(s) and at the then-current Support Service fee(s) thereafter. Prior to the expiration of the Warranty Period, if any, and at each Support Service renewal thereafter, Licensee may select one of the Support Services options in RLIS' then current published price list ("TeleMed Services") and RLIS shall provide the Support Services at the then current fee(s) in acceptance with the terms of the selected option as set forth in such price list. Updates to the Program(s) shall not extend the term of any Warranty Period.

WARNING: Failure to implement Quarterly Updates within the 45 day time period will result in automatic shutdown of the prescription and medications components of the TeleMed system.

Licensee assumes all risks arising from Licensee's failure to implement updates and any other corrections released by RLIS and from implementation of Program modifications not supplied by RLIS. Support Services will be provided by mail, telephone or on-site as specified under the Support Services option selected by Licensee.

Support Services for the first year of Support Services purchased by Licensee following the Warranty Period will be due forty-five (45) days prior to closure of Warranty Period. Support Services are renewable on an annual basis thereafter at RLIS' then-current applicable Support Services fees, which will be due on or before each anniversary of the expiration of the Warranty Period. If Licensee fails to renew Support Services, RLIS shall thereafter have no obligation to correct or support the Program(s). Notwithstanding the above, RLIS may at any time, upon one year's notice to Licensee, terminate Support Services for any Program(s).

9. Quarterly Updates. Quarterly Program updates are distributed by RLIS to implement changes in prescription, standard forms or medical information. These updates will be distributed the first business day of the following months: January, April, July, October. Quarterly Updates must be installed within 45 days of distribution.

WARNING: Failure to implement Quarterly Updates within the 45 day time period will result in automatic shutdown of the prescription and medications components of the TeleMed system.

NOTE: In the interest of practicing good medicine, these Quarterly Updates address: pharmaceutical database updates, 3rd party licensing terms, medical knowledge base updates and other enhancements as required for prudent medical practice.

10. Termination of License. RLIS may terminate this Agreement or the License for any and all Program(s), effective immediately upon written notice to Licensee, if Licensee fails to perform any of its obligations under this Agreement and fails to remedy such breach within thirty (30) days after RLIS gives Licensee written notice of the breach.

In the event that this Agreement for a License is terminated for any reason, Licensee shall promptly return to RLIS the original and all copies of the Program(s), including all documentation covered by the terminated License(s). The provisions set forth in section 5, 6, 8 and 12 of this Agreement shall survive any termination of the License.

11. U.S. Government Restricted Rights. If Licensee is a U.S. government agency or government subcontractor, Licensee hereby acknowledges that the computer programs comprising the Program(s) are commercial computer software developed at private expense and provided to Licensee subject to RESTRICTED RIGHTS, and all other Programs' technical data, including without limitation any user manuals and other documentation, are provided to Licensee subject to LIMITED RIGHTS. The terms "commercial computer software," "private expense," "RESTRICTED RIGHTS" and "LIMITED RIGHTS" as used in this section 9 are defined in 48 CFR: DFAR 252.227-7013, FAR 52.227-19 and DFAR 52,227-7013.

Licensee agrees that it will not remove or permit to be removed the following legend and notice printed on the Program(s) and will place this legend and notice on all copies made by Licensee:

RESTRICTED RIGHT LEGEND - Use, duplication or disclosure by the Government is subject to restrictions as set forth in subparagraph (c) (i) (ii) of the Rights in Technical Data and Computer Software clause at DFAR 252.227-7013 (48 CFR).
Contractor/manufacturer is RLIS, Inc., 4319 Medical Drive #131-341, San Antonio, Texas 78229

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12. Exportation. Licensee shall comply with all applicable laws, including, without limitation, the export control laws of the United States of America and other countries and the relevant regulations issued by the United States Department of Commerce and Department of State, concerning the import, export and re-export of the Program(s), any other accompanying documentation and the direct products thereof. Without limiting the generality of the foregoing, Licensee shall not, and Licensee hereby assures RLIS that it will not, allow the export or re-export, directly or indirectly, of any Program, accompanying documentation or the direct products thereof unless prior written authorization is obtained from RLIS and, where required, the United States government.

13. Third Party Products. If the Program(s) include any third party computer programs or other products, then the following terms shall apply to such third party products and in the event of a conflict between this Agreement and the following terms, the following terms shall govern with respect to third party product: (i) any shrink-wrap agreement or other terms or conditions included in the third party product packaging or documentation; and (ii) any terms or conditions applicable to third party products that are attached to, or incorporated into, a "Schedule."

14. Severability. If any provision of this Agreement, or portion thereof, or the application thereof to any circumstance shall be held to be invalid or unenforceable, the remainder of this Agreement and the application thereof to other circumstances shall be nevertheless valid. In lieu of such invalid or unenforceable provision, there shall be added automatically a provision as similar in terms to such invalid or unenforceable provision as may be possible and be legal, valid and enforceable

15. General. This Agreement sets forth the entire agreement and understanding of the parties relating to the subject matter hereof and supersedes any and all oral and prior written agreements, understandings and quotations relating thereto. No alteration, modification or cancellation of any of the provisions of this Agreement shall be binding unless made in writing and signed by officers of the parties. Printed terms and conditions on Licensee's Purchase Order(s) shall not apply to Program(s) obtained hereunder. This Agreement will be governed by, and construed and enforced in accordance with, the substantive law of the State of Texas, USA. The UN Convention on the International Sale of Goods shall not apply. The English language versions of this Agreement shall govern.

This Agreement shall be binding upon and inure to the benefit of the parties and their respective successors, permitted assigns and legal representatives.

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